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ABSTRACT

This report describes the activities of a personnel preparation special project which developed, implemented, and evaluated a training model focusing on materials and collaborative activities necessary for effective delivery of early intervention. The collaborations focused on three areas: interagency collaborations, cross-disciplinary collaborations, and family collaborations. Within each of these areas, a number of sub-areas were highlighted. Interagency collaborations emphasized the service coordination and transition process. Cross-disciplinary collaborations included the assessment and service delivery process. Lastly, family collaborations centered around the development of Individualized Family Service Plans and the use of family support strategies. The training materials and activities developed were targeted at two audiences, early intervention staff and faculty from institutions of higher education. The training activities and materials were piloted with both target audiences in Connecticut during the first two years of the project, and the model was available for national dissemination during the third year. Evaluation focused on the training materials, training activities, trainee outcomes, and program impact. The report includes the service providers' inservice manual, preservice higher education manuals, participant data, and a dissemination list. (Contains 92 references.) (CR)

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Preservice and Inservice Training for Early Intervention Collaboration: Across Agencies, Professionals and Families

FINAL REPORT

Office of Special Education Projects
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ABSTRACT

Personnel Preparation Special Project

An Office of Special Education Project

Mary Beth Bruder, Ph.D.
Project Director

This personnel preparation special project developed, implemented and evaluated a training model which consisted of materials and activities on collaborations necessary for effective delivery of early intervention. The collaborations focused within three areas: interagency collaborations; crossdisciplinary collaborations and family collaborations. Within each of these areas, a number of sub-areas were highlighted. Interagency collaborations emphasized the service coordination and transition process. Crossdisciplinary collaborations included the assessment and service delivery process. Last, family collaborations centered around the development of Individual Family Service Plans and the use of family support strategies. The training materials and activities which were developed were targeted at two audiences: early intervention staff; and faculty from institutions of Higher Education. The training activities and materials were piloted with both target audiences within the state of Connecticut during the first two years of the project, and the model was available for national dissemination during the third year. Evaluation focused on the training materials, training activities, trainee outcome and program impact.

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1. Project Overview

One of the underlying principles of Part H of P.L. 102-119 is collaboration. Collaboration is inherent in any early intervention service delivery system for infants, toddlers and their families. Yet, few personnel preparation programs for disciplines involved in early intervention provide training on collaborative skills (Bailey, Palsha, & Huntington, 1990). Likewise, most inservice training programs offered as a part of a state's Comprehensive System of Personnel Development for Part H services do not include content specific to collaborations (Bruder & McCollum, 1991). It seems reasonable to conclude that if P.L. 102-119 is to be effective, the personnel involved in the delivery of early intervention services must be provided training specific to the program's requirements.

This project developed, implemented, and evaluated training materials and activities for both preservice and inservice use on the collaborative process in early intervention. The collaborative process focused on three key areas essential for the delivery of early intervention: family-centered: collaborations. crossdisciplinary collaborations, and interagency collaborations. The training content which was developed for these three areas included such topics as collaborative strategies to use when developing Individualized Family Service Plans and family support services. Other topics included the development of crossdisciplinary assessment and service delivery strategies. Last, transition activities and service coordination strategies were also highlighted. These content areas are contained in Figure 1.

The materials and activities were developed for use in both preservice and inservice training programs. During the first two years of the project, the inservice training was piloted and implemented in Connecticut. The preservice training was also piloted during year one in Connecticut, and was available throughout the region in year two. During the third year, the project disseminated the materials and activities throughout the country.

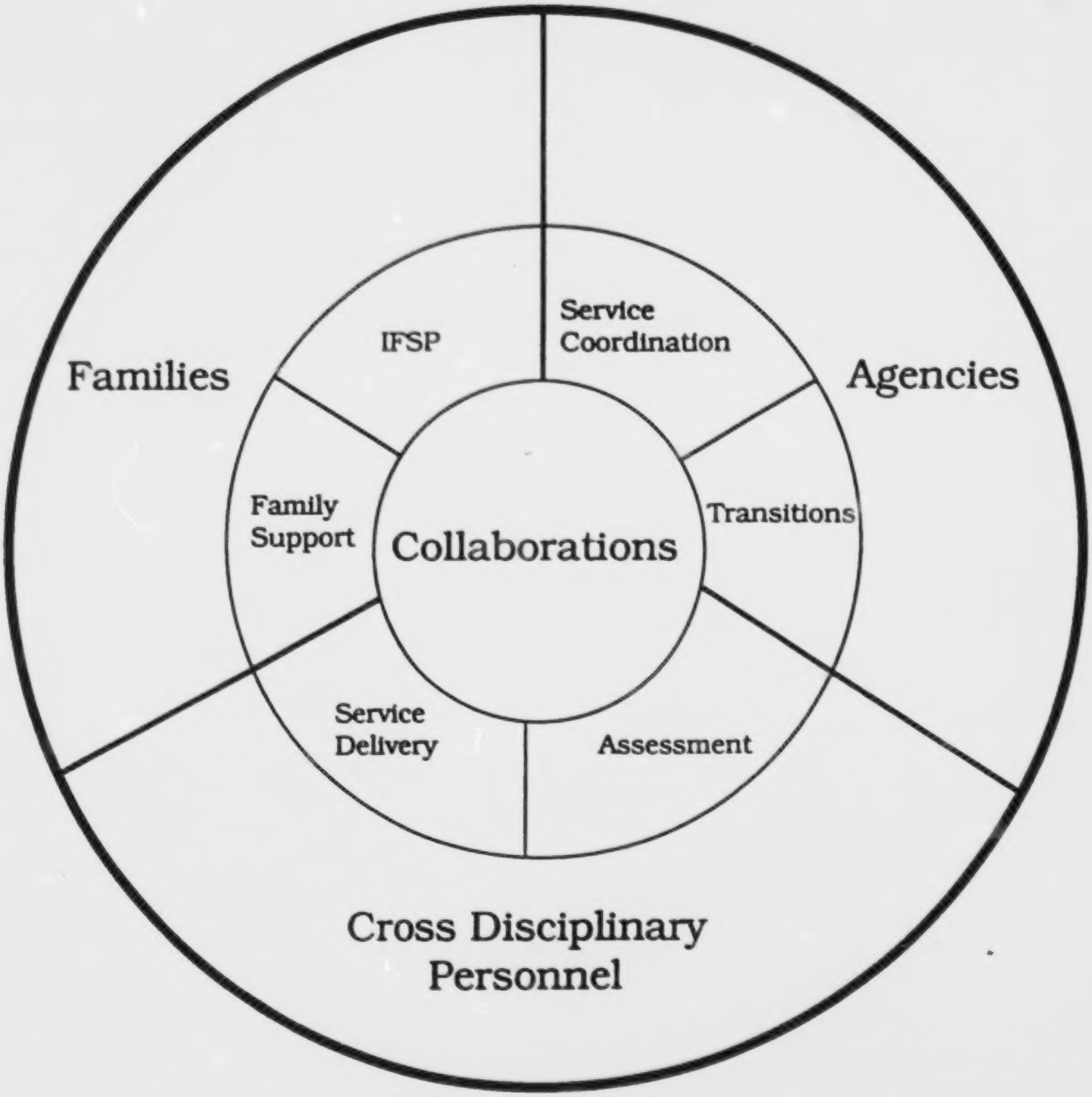
Families
Agencies
IFSP
Service Coordination
Family Support
Collaborations
Transitions
Service Delivery
Assessment
Cross Disciplinary Personnel

Figure 1
Scheme of Training Model

2. Need for Project

Need for Early Intervention Personnel

The task of increasing the number of qualified personnel available to implement early intervention services must be addressed by all states participating in Part H of P.L. 99-457. The programmatic requirements of this law include the establishment of a Comprehensive System of Personnel Development (CSPD) and the adoption of personnel standards. While these are only two of the 14 service components which are required of the states participating in P.L. 99-457, they represent a critical area which must be addressed before each state can be assured of its ability to implement the full scope of services required by the law (Bruder & McCollum, 1991; Gilkerson, Hilliard, Schrag, & Shonkoff, 1987; Meisels, Harbin, Modigliani, & Olson, 1988; Smith & Powers, 1987; Woodruff, McGonigel, Garland, Zeitlin, Chazkel-Hochman, Shanahan, Toole, & Vincent, 1985).

Changing models of early intervention. The unique needs of infants and families eligible for early intervention have created a challenge to service providers. Both federal legislation (P.L. 99-457), and recommended practice (Brewer, McPherson, Magrab, & Hutchins, 1989; Shelton, Jeppson, & Johnson, 1987), now suggest that infant intervention programs be family-centered, comprehensive, community-based and coordinated. At this time, state and local service agencies are struggling with the development of early intervention programs which encompass the above mentioned characteristics. In designing such services, a great number of variables must be addressed (cf. Woodruff, et al., 1985).

Most often, programs for infants with special needs consist of those services which are already available within their geographic location. While meeting the needs of some families, other families may require a number of additional services which may be difficult to access. For example, an infant may be required to participate in a hospital follow-up clinic, hospital or home-based therapy services, home health services (including equipment maintenance services), and early intervention program services. These services may have limitations on the types, frequencies and locations of their delivery, and these limitations may dictate the options (or lack thereof) available to the family. Additionally, the agencies providing the services may have differing goals, orientations, funding sources, services, and eligibility requirements that may further limit their availability. Although it is clear that few agencies have the resources to provide a total continuum of services to deal with all the problems that may impinge upon an infant with disabilities and his/her family, services should be structured in such a way as to maximize coordination and collaboration, and enhance, rather than inhibit, family functioning (Dunst & Trivette, 1989).

Changing roles for professionals. It has been documented that early intervention is facing a critical shortage of personnel trained to provide services under P.L. 99-457 (Meisels, 1989; Meisels, et al., 1988). This shortage is expected to last well into the 1990's and it is occurring across many disciplines. In particular, data have been collected on shortages within special education (McLaughlin, Smith-Davis, & Burke, 1986; Office of Special Education Programs, 1989), occupational therapy (National Easter Seal Society, 1988; OT News, 1989), physical therapy, (National Easter Seal Society, 1988), nursing (Division of Nursing, Bureau of Health Professionals, 1987) and speech and language pathology (Yoder & Coleman, 1990). Additionally, the Bureau of Labor Statistics (1988) estimates employment growth rates of 36% for preschool teachers and 42% for health professionals by the year 2000. They predict the fastest growing occupations during this time period to be physical therapists, physical therapy aides, home health aides, physician's assistants and occupational therapists.

This shortage of early intervention personnel has resulted, in part, from the specialized requirements of infant/toddler service delivery under the new law. These requirements include the development of competencies and skills which are qualitatively different from the skills typically included in programs training personnel to work with school or preschool aged children (Bailey, 1989b; Bailey, Farel, O'Donnell, Simeonsson, & Miller, 1986; Bricker & Slentz, 1988; Fenichel & Eggbeer, 1990; McCollum & McCarten, 1988; McCollum & Thorp, 1988; Thorp & McCollum, 1988). For example, the law requires that professionals from multiple disciplines be trained to collaboratively assess infants, toddlers and their families, develop an individual family service plan in collaboration with families, and assist families to coordinate services. In particular, the family focus is unique to this age group, and thus demands additional skills beyond traditional child-focused intervention skills.

In examining the current status of training program for professionals specializing in early intervention, criticism has been leveled at the type of preservice training which is available to both undergraduate and graduate students. Courtnage and Smith-Davis (1987) conducted a survey of 260 undergraduate programs in special education and found that 48% of them did not offer coursework on interdisciplinary team functioning. Likewise, Bailey and his colleagues (Bailey, Palsha, & Huntington, 1990) surveyed both undergraduate and graduate programs for disciplines listed within P.L. 99-457 (now P.L. 102-119): special education, nursing, occupational therapy, speech and language pathology, physical therapy, audiology, nutrition, psychology and social work. They examined the number of hours of training content available in areas to be provided under the law. These areas included case management, ethics, infant development, infant and family assessment, team processing, and values. **Their results suggested a significant lack of preparation within these areas by the higher education programs who responded to the survey.** Additionally, of those higher education personnel preparation programs that specifically train infant specialists on content required by the law, there seems to be a lack of consensus over the type and number of competencies a trainee should exhibit. An examination of federally funded personnel preparation programs for interdisciplinary infant specialists found that there was a range of 7 to 380 training competencies to be demonstrated by students within the 40 funded programs (Bruder & McLean, 1988).

The lack of available, appropriately trained personnel is compounded by a lack of professional standards specific to early intervention services. The requirement of P.L. 99-457 for professional standards across ten disciplines has not as yet resulted in any nationally adopted requirements. Only two states (New Jersey and Idaho) have adopted standards across a majority of the disciplines, and these standards do not contain competencies specific to infants and toddlers (Bruder, Klosowski, & Daguio, 1989). Though many states are planning to address licensing requirements for P.L. 99-457, there is no guarantee that these requirements will meet specific infancy and

interdisciplinary competencies necessary for the full implementation of the law.

Many recent articles have attempted to respond to the changes in service delivery created by the law by proposing specific training recommendations for each of the ten disciplines. These disciplines include special education (McCollum, McCartan, McLean, & Kaiser 1989; Thorp & McCollum, 1988), occupational therapy (Hanft, 1988; Hanft & Humphry, 1989), physical therapy (Scull & Deitz, 1989), nursing (ANA, 1990; Brandt & Magyary, 1989), social work (Nover & Timberlake, 1989), nutrition (Kaufman, 1989), psychology (Drotar & Sturn, 1989) and medicine (Brewer, McPherson, Magrab, & Hutchins, 1989). The content proposed within these articles include discipline specific skills in both infancy and **families**, as well as **interdisciplinary and interagency skills necessary for the implementation of the law** (Bailey, 1989a; Hanft & Humphry, 1989; Hanson & Lynch, 1989; Fenichel & Eggbeer, 1990; McCollum & Thorp, 1988; Thorp & McCollum, 1988). For example, all disciplines should have thorough knowledge of infant development, identification and assessment strategies, intervention techniques, family systems, and communication strategies. The interdisciplinary skills would include functioning within a team by sharing and utilizing other member's expertise for both assessment and program planning (Fewell, 1983; Foley, 1990; McCollum & Hughes, 1988; McGonigel & Garland, 1988; Spencer & Coye, 1988). All disciplines should also have a working knowledge of interagency coordination and service coordination strategies as required by P.L. 99-457. It must be noted that many of these skills will require supervised practical application in order to insure the trainee has acquired competence in these areas. **The areas of families, crossdisciplinary services and interagency structures will be highlighted through literature to emphasize the need for the proposed project on collaborations.**

Need for Collaborations in Early Intervention

There are many benefits to collaborative service delivery models (Elder & Magrab, 1980). Most importantly, is an improvement in service delivery to the target population. This occurs as a result of more efficient and effective use of services, providers and funding streams across agencies (Audette, 1980; Bailey, 1984). These models also result in a reduction in service duplication (Garland

& Linder, 1988; Healey, Keesee & Smith, 1985). Lastly, collaborative efforts enable parents and service providers to efficiently locate and manage the necessary services required by the family (Bailey, 1989b; Dunst & Trivette, 1988).

Unfortunately, the development of collaborative early intervention service systems remains an elusive goal for many states. This is not surprising considering that the service delivery system is composed of independent agencies, institutions and organizations, and each provide a specific service or function. As a result, each participating service provider has their own orientation toward the service system. For example, hospitals and health professionals view early intervention very differently from community oriented agencies and professionals (Gilkerson, 1990). However, Part H of P.L. 102-119 mandates that many agencies work together to develop joint activities focused on the development of collaborative, early intervention services (Trohanis, 1989).

When examining the unique services required by infants and toddlers with disabilities and their families, the immediate challenge is to identify the various agencies, professionals and payment sources currently involved in the provision of early intervention services in their community. While interagency and crossdisciplinary coordination may be the first step toward alleviating some of a family's needs, the ultimate goal should be the collaborative development of an Individualized Family Service Plan (IFSP) carried out under the direction of the family. The keys to this goal are three: family-centered collaborations, crossdisciplinary collaborations, and interagency collaborations.

Family Centered Collaborations. Parents of young children with disabilities rarely take on this parenting role with any amount of preparation for the special challenges they will face. Rather, the early days, weeks and months of parental responsibility may be spent in a blur of visits to the hospital, physician's office and special clinics with little or no opportunity to adapt to the significant change which has taken place in their lives. While most parents report an increase in the level of stress they perceive as a result of the birth of a child, the parents of a young infant with disabilities must deal with unanticipated pressures and responsibilities that can make the parenting role appear to be overwhelming. Early interventionists must be prepared to assist families to provide care and services which support, rather than supplant their parenting role.

An expanded focus on family systems theory has resulted in the recommendation that early intervention programs move away from a narrow focus of the child and encompass the broader and self-identified needs of the enrolled parents (Blacher, 1984; Turnbull, Turnbull, Summers, Brotherson & Benson, 1986). It has been suggested that the primary goal of early intervention should be to facilitate the parents' awareness of, and adaptation to, the primary role of parenting a child with disabilities. A program can then focus on helping the family address the long range needs of their child (Foster, Berger & McLean, 1981; Vadasy, Fewell & Greenberg, 1985).

Just as the population of children who are considered to have special needs is not a homogeneous group, neither are the children's families. The early intervention professional serving young children with disabilities will no doubt work with a diversity of families who vary by cultural and economic conditions, as well as by family structure (Lynch & Hanson, 1992; Vincent & Salisbury, 1988; Vincent, Salisbury, Strain, McCormick, & Tessier, 1990). Each family will bring unique resources and strengths to the task of parenting their child with special needs, and each family will identify unique priorities which must be addressed through the IFSP process, not the least of which may be the provision of family support services.

Family support is an area which is receiving attention by early intervention programs (Affleck, Tennen, Rowe, Roscher, & Walker, 1988; Bailey & Simeonsson, 1988; Dunst, Trivette, & Deal, 1988). It has been suggested that parents of children with disabilities experience a larger degree of stress than parents of children who are not disabled (Gallagher, Beckman, & Cross, 1983). These stressful events include environmental events (e.g., financial problems which impact basic survival) and biological events (e.g., caretaking demands of a premature, handicapped or medically unstable preschooler). Further, studies have demonstrated that levels of stress among parents are related to the type and degree of disability evidenced by their child (Beckman-Bell, 1981; Bristol, 1979; Holroyd & McArthur, 1976).

A recent suggestion has been for early intervention programs to recognize the ongoing stress that parents of disabled and at-risk young children may be experiencing by helping families adapt to stress through the recruitment of support networks (Affleck, et al., 1988; Bailey & Simeonsson, 1988; Dunst, Trivette & Deal, 1988; Eheart & Ciccone, 1982; Gallagher, Beckman, & Cross, 1983). It has been documented that the social networks of parents exert strong influences on their child-rearing behavior and attitudes. Support for parenting seems to help parents achieve a sense of competence (Abernathy, 1973; Cutrona & Troutman, 1986), as well as become more responsive to the child (Crnic, Greenberg, & Slough, 1986; Pascoe, Loda, Jeffries, & Earp, 1981). Parents who receive more support for the care of young children with disabilities exhibit more positive psychological adaptation (Affleck, Tennen, Allen, & Gershman, 1986; Crnic, Greenberg, Robinson, & Ragozin, 1984; Crnic, Greenberg, & Slough, 1986; Dunst, Trivette, & Cross, 1985; Trause & Kramer, 1983) and more effective involvement in early intervention programs. By changing the focus from child change to parent-family adaptation, service providers, and parents have seen beneficial results (Affleck, Tennen, Rowe, Roscher, Walker, & Higgins, 1989; Bromwich, 1981; Dunst, Trivette, & Deal, 1988; Robinson, Rosenberg, & Bechman, 1988).

It has been suggested that both formal and informal support strategies should be integral to any early intervention service delivery system for families with high-risk or disabled children (Affleck, et al., 1988; Dunst, Trivette, & Deal, 1988). The support strategies should be both formal (e.g., assistance with insurance and financial needs; identification of respite services; training on medical equipment) and informal (e.g., identifying existing community resources; facilitate family involvement within the school). The overriding premise of such support is that it must be individually matched to the needs of the family, and the use of such strategies should be directed by the family. These principles have been articulated as components of family-centered care (Shelton, Jeppson & Johnson, 1987) and these are listed on Table 1. Family-centered care suggests that all services revolve around the family, as it is the family which will be the constant in the child's life. This philosophy is most appropriate for collaborative early intervention models in which services are designed and delivered according to an IFSP.

Table 1

Principles of Family Centered Care

1. Recognition that the family is the constant in the child's life while the service systems and personnel within those systems fluctuate.
2. Facilitation of parent and professional collaboration at all levels of health care.
3. Sharing of unbiased, complete information with the parents about their child's care on an ongoing basis and in an appropriate and supportive manner.
4. Implementation of policies and programs that are comprehensive and provide emotional and financial support to meet the needs of the family.
5. Recognition of family strengths and individuality and respect for different methods of coping.
6. Understanding and incorporating the developmental needs of infants, children and adolescents and their families into health care systems.
7. Encouragement and facilitation of parent-to-parent support.
8. Assurance that the design of health care delivery systems is flexible, accessible and responsive to family needs.

Cross Disciplinary Collaborations. While the development of an IFSP hinges on the effectiveness of family centered collaborations, the actual service delivery must be implemented by individual service providers. There is no doubt that young children with disabilities and their families require the services of a professional with a wide variety of skills. Personnel having medical expertise, therapeutic expertise, educational/developmental expertise and social service expertise are necessary to help establish and implement an effective intervention program. Whether such services are provided through an interagency (across programs) or intra-agency model, the involved personnel will have to adopt a team model to ensure collaborative assessment and service delivery (McCollum & Hughes, 1988). Those involved must be prepared to function in an optimum fashion to meet the self-identified needs of the family as they relate to the infant with a disability. The success of the interventions will be dependent on the way the service provider team functions.

Moving from a group of individuals to a functional service delivery team requires much more then bestowing the label of a team on the group. A group of people become a team when their purpose and function are derived from a common philosophy with share goals (Maddux, 1988). Table 2 contains an overview of the differences between a team and group.

Teams must devote time to identifying their goals and objectives. A truly effective team exists when members share responsibility for accomplishing common goals. An effective team will:

- Have goals which are clearly understood, and communicated to all team members. A collaborative philosophy or mission is the team's overall reason for existence. It provides the team with a focus for its actions. A written statement of the collaborative philosophy will clearly delineate the team's direction. A team will function effectively to the extent that its philosophy is clear and agreed upon.
- Have ownership of the goals and participate in setting them. All the team members (including the family) need to feel that their input is valued. This helps to ensure that the goals are clearly understood by everyone on the team.

Table 2

Groups Versus Teams

GROUPS	TEAMS
Members think they are grouped together for administrative purposes only. Individuals work independently; sometimes at cross purposes with others.	Members recognize their interdependence and understand both personal and team goals are best accomplished with mutual support. Time is not wasted struggling over "turf" or attempting personal gain at the expense of others.
Members tend to focus on themselves because they are not sufficiently involved in planning the unit's objectives. They approach their job simply as a hired hand.	Members feel a sense of ownership for their jobs and unit because they are committed to goals they helped establish.
Members are told what to do rather than being asked what the best approach would be. Suggestions are not encouraged.	Members contribute to the organization's success by applying their unique talent and knowledge to team objectives.
Members distrust the motives of colleagues because they do not understand the role of other members. Expressions of opinion or disagreement are considered divisive and non-supportive.	Members work in a climate of trust and are encouraged to openly express ideas, opinions, disagreements and feelings. Questions are welcomed.
Members are so cautious about what they say that real understanding is not possible. Game playing may occur and communications traps be set to catch the unwary.	Members practice open and honest communication. They make an effort to understand each other's point of view.
Members may receive good training but are limited in applying it to the job by the supervisor or other group members.	Members are encouraged to develop skills and apply what they learn on the job. They receive the support of the team.
Members find themselves in conflict situations which they do not know how to resolve. Their supervisor may put off intervention until serious damage is done.	Members recognize conflict is a normal aspect of human interaction but they view such situations as an opportunity for new ideas and creativity. They work to resolve conflict quickly and constructively.
Members may or may not participate in decisions affecting the team. Conformity often appears more important than positive results.	Members participate in decisions affecting the team but understand their leader must make a final ruling whenever the team cannot decide, or an emergency exists. Positive results, not conformity are the goal.

From: Maddux, R.E. (1988). Team Building: An Exercise in leadership. Crisp Publications.

- Have goals which are operationally defined and measurable. Goals must be written in such a way that everyone has a clear understanding of what is expected, and how successful mastery of the goal is to be determined and measured.
- Share individual or personal objectives with one another. Since teams are comprised of individuals, it is important to respect the human element that exists within any team. This is a key component of effective teams.

The types of teams that typically function within early intervention have been identified as multidisciplinary, interdisciplinary and transdisciplinary. While the transdisciplinary team model has been identified as the ideal for early intervention, other team models have been identified and used for assessment service delivery (Gibbs & Teti, 1990; Hanson & Lynch, 1989; McGonigel & Garland, 1988; Raver, 1991). The term crossdisciplinary will be used in this proposed project to describe a team which functions around the needs of the family as opposed to the needs of discipline specific service providers.

On a crossdisciplinary team, the members share roles and systematically cross disciplinary boundaries in accordance to the assessment or service delivery needs as identified by the family. The communication style in this type of model involves continuous give and take between all the members of the team (especially the family) on a regular, planned basis. Professionals from different disciplines teach, learn and work together to accomplish a common set of service goals for a child and their family. The role differentiation between disciplines is defined by the needs of the situation, as opposed to discipline specific characteristics. Assessment, intervention, and evaluation are carried out jointly by designated members of the team. Other characteristics of this team are joint team effort, joint staff development and role release.

Role release refers to a "sharing and exchange of certain roles and responsibilities among team members" (Lyon & Lyon, 1980; Orelove & Sobsey, 1991). It specifically involves a "releasing" of some functions traditionally associated with one's primary discipline. Effective implementation of the role release process requires adequate sharing of information and training. Team members must have a solid foundation in their own discipline combined with a knowledgeable base that recognizes the roles and competencies of the other disciplines represented on the team.

Role release may mean that one discipline implements intervention traditionally associated with that of another discipline. However, team members continue to be recognized as the authority and resource for their own primary discipline. Role release is not role swapping. After techniques are appropriately taught to another discipline, they must continue to be monitored or supervised by the authoritative discipline. The concept of role release also recognizes that parents and other family members have valuable expertise and must be considered a vital part of the service delivery team. Their involvement in the team process must be actively encouraged by all team members.

As with effective interagency service delivery models, collaboration is inherent in the transdisciplinary team approach. A crossdisciplinary team is one in which the members perceive that they can obtain their own goal if, and only if, the other team members also obtain their respective goals. The collaborative team model may be described as a three step process in which members: 1) develop positive interdependence (agreeing to do all that is in their power to achieve a mutually accepted goal); 2) practice collaborative skills; and 3) monitor and discuss their performance of collaborative behaviors (Fox, et al., 1986).

Interagency Collaboration It is clear that few agencies have the resources to provide a total continuum of services which encompasses all the issues that may impinge upon a young child with disabilities and his/her family. Therefore, agencies, programs, and staff must be prepared to cooperate and collaborate for the benefit of families. For example, an infant of Puerto Rican heritage who was prenatally exposed to drugs requires the expertise and services of bilingual early intervention staff, medical staff and community agency staff.

The development of cooperative arrangements among agencies for the purpose of service delivery (e.g., early intervention and community early childhood programs) is a common strategy which has been used to improve the existing structure (Shenet, 1982). Cooperative arrangements are required by many federal laws and the desired outcome is the development of an interagency cooperative agreement. However, cooperative arrangements rarely result in improved services (Melaville & Blank, 1991). This is because cooperating agencies maintain their own autonomy, as well as their own philosophy and service goals, and not all may be appropriate for the target population. Other additional barriers have been identified which may impinge further on the successes of interagency models. These appear on Table 3. Unfortunately, this model tends to drive most initial attempts to cooperatively provide services from more than one agency for young children with disabilities and their families.

In order to improve this situation, it has been suggested that the focus of interagency models should shift from cooperative arrangements among agencies to collaborations focused on joint service delivery. A collaborative strategy is called for in communities where the need and intent is to fundamentally change the way services are designed and delivered (Melaville & Blank, 1991). This requires the involved agencies to agree on a common philosophy and service goal which can only be achieved by joint agency activities. This is most appropriate when implementing an early intervention program which utilizes family centered collaborations and crossdisciplinary collaborations for service delivery.

A systematic process of problem solving increases the likelihood that interagency collaborations will be successful. Systematic problem solving will ensure that the participating agencies are satisfied with, and committed to, the decisions that are made. There are a variety of problem solving models that have been developed. For example, PROJECT BRIDGE (Spencer & Coye, 1988) has developed a five step decision making model which can easily be applied to the collaborative process. It has been recommended that each step in the problem solving process should be used as a check point for agencies to evaluate their ideas and practices in relationship or comparison with best practices for exemplary services in the field of early intervention. The steps include:

Table 3
Common Barriers to Interagency Collaboration

COMPETITIVENESS BETWEEN AGENCIES

- Turf Issues
- Lack of Information About other Agency's Functions
- Political Issues

LACK OF ORGANIZATIONAL STRUCTURE FOR COORDINATION

- Differing Philosophies
- Independent Goals
- Haphazard Team Process
- Lack of a Facilitator
- Lack of Monitoring and Evaluation Process
- Lack of Planning
- Lack of Power and Authority to Make and Implement Decision

TECHNICAL FACTORS

- Resources: Staff, Time, Budget
- Logistics: Distance, Geography

PERSONNEL

- Parochial Interests
- Resistance to Change
- Staff Attitudes
- Lack of Commitment to Community Needs
- Questionable Administrative Support
- Discipline Specific Jargon and Perspectives

Problem Formulation and Information Gathering. The problem must be described in clear and observable terms. Resources should be identified, and the involved agencies should focus on the facts, rather than opinions.

Generating Proposals for Solution. As many alternatives as possible should be generated from all involved in the process. All suggestions should be viewed positively.

Selecting Alternatives and Testing Solutions. The agencies must judge the available resources, and evaluate the alternatives for the solution. They must then decide whether or not the solution makes good use of the resources, is cost effective, and fits the needs and goals involved.

Action Planning and Implementation. The agencies should assign specific responsibilities, determine timelines, and develop procedures for monitoring the plan. The plan is then communicated to all relevant personnel.

Monitoring and Evaluation. The agencies should determine how to judge the success of their decision. They should select a unit of evaluation, decide how often to evaluate, and plan to modify the collaboration as needed.

3. Problem That Was Addressed

Early intervention legislation requires a focus on skills not previously taught by personnel preparation programs. This legislation has resulted in 20 states fully implementing all components of P.L. 102-119. Other states will be in full implementation within the next two years.

Early interventionists who are providing services under the law must be prepared to collaborate across agencies and professionals to develop Individualized Family Service Plans under the direction of the family. In addition, the services should be delivered to the extent appropriate in natural environments. These setting characteristics, in particular, rely on the ability of the service provider to collaborate with personnel outside the early intervention realm (e.g., child care providers).

Training materials and activities must be made available to personnel providing early intervention as part of each states' CSPD under Part H of P.L. 102-119. The content of this training should reflect skills necessary for the effective implementation of services under the law. At this time, there are materials available on the collaborative consultation process, but most focus on the provision of classroom services to school age children with disabilities (Villa & Thousand, 1992). Only recently, has attention been called on the need for collaborative skills in early intervention (e.g., Hanson & Widerstrom, 1992; Kagan, 1991; Melaville and Blank, 1991). Unfortunately, confusion exists in regard to the meaning of collaboration, especially within early childhood services (Kagan, 1991).

Collaboration is a term used to describe a relationship between two or more persons, programs or agencies. It has also been defined as a process of problem solving by team members, each of whom contributes his or her knowledge and skills equally (Vandercook & York, 1990). A variation of collaboration, called collaborative consultation, has been defined as "an interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems" (Idol, Paolucci-Whitcomb & Nevin, 1986, p IX). A positive atmosphere of communication and trust ensures that effective problem solving occurs.

It has recently been suggested that collaboration represents the culmination of a process which embodies a variety of strategies. These strategies include cooperation and coordination, which are less formal, but more prevalent, than collaborative relationships (Kagan, 1991). For the purpose of this proposal and the training which will be developed and implemented as part of the project, collaboration will be defined as organizational and interorganizational structures where resources, power and authority are shared and where people are brought together to achieve common goals that could not be accomplished by a single individual or organization independently (Kagan, 1991, p 3). **Currently, there are few training models available to prepare early interventionists (at both preservice and inservice levels) to develop and implement collaborative strategies to enhance the delivery and effectiveness of early intervention**.

4. Goal

The goal of this project was to develop, implement and evaluate training materials and activities on the collaborative process within early intervention focusing on three service areas: families, personnel, and agencies.

Progress Report

The Preservice and Inservice Training for Early Intervention Collaboration Project began implementation in October of 1993. This section contains the status of the project results. Table 4 contains the project timelines as proposed. The project staff vitas are in Appendix A.

Objective 1.0 Materials Development

Activity 1.1 Convene advisory board. An advisory board has been convened. Its membership is as follows:

Geri Kogut	Meriden Local Interagency Coordinating Council
Michele White	Bridgeport Local Interagency Coordinating Council
Janet Dougan	SE Regional Community Coordination Council
Maria Synodi	Department of Children and Families
Marie Rogers	Department of Mental Retardation
Sharon Friez	Infant and Child Development Services
Lynn Faria	Executive Director, Easter Seal of Central Connecticut
Joan Brinckerhoff	Part H Coordinator, Department of Education
Marianne Kirner	Director, Special Education Resource Center

There have been continuous meetings of the advisory board. In addition, project staff have been asked to facilitate statewide meetings of the Local Interagency Council representatives. This group has also acted as a continuous advisory board to the project.

Table 4
Activity Timelines

Quarters

		Year 1				Year 2				Year 3			
Objectives/Activities		1	2	3	4	5	6	7	8	9	10	11	12
1.0	**Materials Development**												
1.1	Convene advisory board	X											
1.2	Outline pertinent brochure, manual content	X											
1.3	Develop, print brochure				X								
1.4	Develop three manuals	X	X	X									
1.5	Print three manuals			X									
1.7	Field test manuals with early interventionists			X	X								
1.8	Field test manuals with faculty			X	X								
1.9	Reconvene advisory board		X	X	X	X	X	X	X	X	X	X	X
1.10	Refine manuals					X	X						
1.11	Print manuals							X	X				
1.12	Disseminate manuals									X	X	X	X
2.0	**Inservice Training**												
2.1	Recruit participants						X	X	X	X	X	X	X
2.2	Develop additional activities					X	X						
2.3	Implement content from manuals and additional activities as training							X	X	X	X	X	X
2.4	Supervise student on practicum assignments							X	X	X	X	X	X
2.5	Institute materials and activities in CSPD							X	X	X	X	X	X

Table 4
Activity Timelines

	Quarters											
	Year 1				Year 2				Year 3			
Objectives/Activities	1	2	3	4	5	6	7	8	9	10	11	12
3.0 Preservice Training												
3.1 Recruit faculty participants							X	X	X	X	X	X
3.2 Develop additional activities for training						X						
3.3 Implement training materials and activities							X	X	X	X	X	X
3.4 Institute materials and activities in CSPD									X	X	X	X
4.0 Disseminate Materials and Activities												
4.1 Publicize availability of materials and training activities							X	X	X	X	X	X
4.2 Provide training as inservice activity							X	X	X	X	X	X
4.3 Provide training as preservice activity							X	X	X	X	X	X
4.4 Send out manuals for use by others									X	X	X	X
5.0 Evaluate Project												
5.1 Evaluate materials	X	X	X	X	X	X	X	X	X	X	X	X
5.2 Evaluate inservice activities	X	X	X	X	X	X	X	X	X	X	X	X
5.3 Evaluate preservice activities	X	X	X	X	X	X	X	X	X	X	X	X
5.4 Evaluate dissemination activities						X	X	X	X	X	X	X

Activity 1.2 Outline brochure, and manual content. The manuals were outlined in year 1 of the project.

Activity 1.3 Print brochure. This was completed by the end of our second year.

Activity 1.4 Develop training manuals. A number of activities have occurred as a result of beginning to develop the manuals. A number of audiences requested input to these materials. Most requests were received as a result of publicizing our project through the advisory board and other forums. In particular, a number of activities were sponsored by the project in an attempt to get more information from consumers on the manual content (see last year's continuation report). Based on this input, we have developed one manual for service providers for inservice purposes and families and two for Higher Education faculty for preservice purposes.

Activity 1.5 Print manuals. The final, revised manuals are in Appendix B (service providers inservice manual) and Appendix C (preservice higher education manuals).

Activity 1.7 Field test inservice manuals with early interventionists. We field tested the manuals with a variety of audiences who volunteered for this activity. These include the Department of Mental Retardation Early Intervention Program staff; the Northcentral Family Coordination Center; families who are on New York State Local Interagency Coordinating Councils, and four Local Interagency Coordinating Councils in Connecticut.

Activity 1.8 Field test preservice manuals with higher education faculty. We field tested the manuals with the Connecticut Higher Education Consortium sponsored by the Northeast Regional Early Intervention Higher Education Institute (sponsored by EEPCD; co-directed by Bruder). The Connecticut Team coordinators are Molly Cole, parent, Joan Brinckerhoff, Part H director, Helen Althorp and Regina Miller, faculty from Central Connecticut State University and University of Hartford respectively. The manuals are designed to be used as course material by the faculty.

Activity 1.9 Reconvene advisory board. This activity is ongoing.

Activity 1.10 Refine manual. This has begun after field testing.

Activity 1.11 Print manuals. This occurred at the end of year 2

Activity 1.12 Disseminate manuals. This occurred during year 3.

Objective 2.0 Inservice Training

Activity 2.1 Recruit participants. Participants were recruited through the Birth to Three service delivery system in Connecticut. Brochures and letters were used to recruit individual participants.

Activity 2.2 Develop additional activities. Activities were developed and embedded throughout the training manuals.

Activity 2.3 Implement content from manuals and additional activities as training. Training occurred as either a workshop on one topic (family, team or interagency collaborations) or as an institute which covered all three areas. Data on the participants of eight groups that received institute training is in Appendix D.

Activity 2.4 Supervise students on practicum assignments. Students were supervised by project staff as they completed assignments from the manual.

Activity 2.5 Institute materials and activities in CSPD. This did not occur formally, as the Connecticut Birth to Three system is only now (1998) developing a formal CSPD system.

Objective 3.0 Preservice Training

Activity 3.1 Recruit faculty participants. Faculty who participated in the Northeast Regional Higher Education Faculty Institute participated in the training. Appendix E contains a listing of these faculty who represented 11 states.

Activity 3.2 Develop additional activities for training. Additional activities were embedded within the two manuals for higher education faculty.

Activity 3.3 Implement training materials and activities. Training was also implemented with one early intervention class at the graduate level. Appendix F contains information on the students in the course.

Activity 3.4 Institute materials and activities in the CSPD. See Activity 2.5.

Objective 4.0 Disseminate Materials

Activity 4.1 Publicize availability of materials and training activities. This occurred through mailing throughout the Birth to Three system, and the national Part H system.

Activity 4.2 Provide training as inservice. Eight training institutes occurred during two years of training.

Activity 4.3 Provide training as preservice. Training occurred through the Northeast Region. All participants listed in Appendix E received training materials to use in their state. A graduate class in early intervention was also offered on collaborations (Appendix E).

Activity 4.4 Disseminate materials. In addition to the above mentioned dissemination mechanisms, the materials were offered to all part H coordinators. Appendix G contains a sample listing of those that received the training.

Objective 5.0 Evaluate Project

Appendices C-G contain data on project implementation.

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APPENDIX A

VITA

MARY ELIZABETH BRUDER, Ph.D.

Professional Experience:

1988-Pres.	Associate Professor, Department of Pediatrics, University of Connecticut School of Medicine, Farmington, CT
1988-Pres.	Director, Division of Child and Family Studies, Department of Pediatrics, University of Connecticut School of Medicine, Farmington, CT
1990-1993	Director, Family Support/Early Intervention, Westchester Institute for Human Development, New York Medical College, Valhalla, NY
1988-1990	Director, Pediatric Research and Training Center, Department of Pediatrics, University of Connecticut School of Medicine, Farmington, CT
1986-1988	Assistant Professor, Department of Pediatrics, University of Connecticut School of Medicine, Farmington, CT
1986-1987	Training Director, Pediatric Research and Training Center, Department of Pediatrics, University of Connecticut School of Medicine, Farmington, CT
1985-1986	Early Intervention Co-coordinator, Virginia Institute on Developmental Disabilities, Virginia Commonwealth University, Richmond, VA
1983-1986	Assistant Professor of Special Education, Coordinator of Early Childhood Special Education, Virginia Commonwealth University, Richmond, VA
1983	Instructor, Special Education-Severely Handicapped Program, University of Oregon, Eugene, Oregon
1981-1983	Coordinator, Parent Education Program, Infant Monitoring Project, University of Oregon, Eugene, Oregon
1980-1981	Coordinator, Early Intervention Demonstration Program, University of Oregon, Eugene, Oregon
1980-1982	Training Supervisor, Early Childhood-Special Education/Severely Handicapped Masters Program, University of Oregon, Eugene, Oregon
1979-1980	Research Assistant, Center on Human Development, University of Oregon, Eugene, Oregon
1976-1979	Classroom Teacher, Ira Allen Essential Early Education Center, Burlington Public Schools, Burlington, Vermont
1978	Intern, Bureau of Education of the Handicapped, United States Department of Health, Education and Welfare

Professional Activities/Organizations:

1994-1997	Associate Editor, Journal of Early Intervention
1993-Pres.	Editorial Board, Mental Retardation
1993-Pres.	Advisory Board, National Early Childhood Technical Assistance System, University of North Carolina, Chapel Hill
1993-Pres.	Advisory Board, Northeast Regional Resource Center, Trinity College, Burlington, Vermont
1993-1996	Publications Chair, Governing Board, International Division of Early Childhood, Council for Exceptional Children
1991	Testified before the U.S. House of Representatives Subcommittee on Select Education on the reauthorization of Part H of the Individuals with Disabilities Act
1989-1994	Editorial Board, Journal of Early Intervention
1989-Pres.	Editorial Board, Topics in Early Childhood Special Education
1989-1991	Personnel Preparation Task Force, Connecticut Birth to Three Interagency Coordinating Council,
1989-1990	Promotions Committee, Department of Pediatrics, University of Connecticut School of Medicine

1988-1989	Advisory Board, Least Restrictive Environment Training Standards, Connecticut State Department of Education
1988-1991	Chair, Connecticut Higher Education Council for Early Intervention
1987-1988	Co-Chair, Connecticut Council for Exceptional Children, Division of Early Childhood
1985-1986	Chair, Research Committee, School of Education, Virginia Commonwealth University
1984-1986	Chair, Virginia Early Childhood Special Education, Higher Education Council,
1984-1986	Chair, Virginia Early Intervention Network,
1979	Testified before U.S. Senate Subcommittee on Labor and Education on the reauthorization of P.L. 94-142, The Education of All Handicapped Children Act

Education:

University of Oregon Eugene, Oregon	Ph.D.	1983	Developmental Disabilities Early Childhood
University of Oregon Eugene, Oregon	M.S.	1981	Developmental Disabilities Early Childhood
Trinity College Burlington, Vermont	B.A.	1976	Psychology-Special Education

Publications:

Bruder, M. (1994). Working with members of other disciplines: Collaboration for success. In M. Wolery & J.S. Wilbers (Eds.). **Including children with special needs in early childhood programs**. Washington, DC: National Association for the Education of Young Children.

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Grant Experiences:

Director, Collaborations in Early Intervention, Special Project, U.S. Department of Education, 1993-1996

Director, Analysis of Staffing Patterns in Early Intervention, Field Initiated Research Project, U.S. Department of Education, 1993-1996

Director, Early Intervention Collaborative Inservice Project, U.S. Department of Education, 1993-1996

Director, Hartford Collaborative Demonstration Project, U.S. Department of Education, 1993-1998

Director, Community Inclusion Outreach Project, U.S. Department of Education, 1993-1996

Director, Early Intervention: Project Connect, U.S. Department of Health and Human Services Maternal and Child Health Bureau, 1993-1996

Director, Training for Inclusion Child Care Project, Connecticut Department for Social Services, 1993-present

Director, Physicians Training Project, U.S. Department of Education, 1992-1995

Director, Social Competency Experimental Research Project, U.S. Department of Education, 1992-1995

Co-Director, Higher Education Faculty Inservice Project, U.S. Department of Education, 1992-1995

Director, M.P.H. Program for Nurses focusing in Early Intervention, U.S. Department of Education, 1991-1994

Director, Faculty and Related Services Inservice Project, U.S. Department of Education, 1990-1993

Director, Birth to Three Inservice Outreach Project, U.S. Department of Education, 1990-1993

Director, Niños Especiales Outreach Project, U.S. Department of Education, 1990-1993

Director, Interdisciplinary Masters Degree Program for Infant Specialists, U.S. Department of Education, 1990-1993

Director, Masters Degree Program for OT/PT in the Schools, U.S. Department of Education, 1990-1993

Director, Standards for Community-Based Services for Children with Complex Medical Needs, U.S. Department of Education, 1989-1992

Director, Partners for Policymaking, Connecticut Developmental Disabilities Council, 1990-1991

Director, Policy Institute for Examining Barriers to Home Care, U.S. Department of Education, 1989-1991

Director, Birth to Three Integrated Service Delivery Project, U.S. Department of Education, 1989-1992

Director, Multidisciplinary Inservice Training for Day Care Providers, U.S. Department of Education, 1989-1992

Director, Personnel Preparation Project for Infant Specialists, U.S. Department of Education, 1989-1992

Director, Integrated Preschool Service Delivery Project, U.S. Department of Education, 1988-1991

Director, Day Care Training Project, Connecticut Department of Human Resources, 1987-1990

Director, Birth to Three Inservice Demonstration Project, U.S. Department of Education, 1987-1990

Director, Personnel Preparation Institute for Interdisciplinary Infant Specialists, U.S. Department of Education, 1987-1990

Director, Niños Especiales Outreach Project, U.S. Department of Education, 1986-1989

Director, Personnel Preparation Project for Early Childhood and Infant Special Educators, U.S. Department of Education, 1984-1986

Director, Developmentally Disabled Parent-to-Parent Project, Virginia Developmental Disabilities Program, 1984-1986

Director, Parent-to-Parent Monitoring Program, U.S. Department of Education, 1984-1987

Updated Vita, September, 1994

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Concentration in Finance and Human Resources Management

B.S., Trinity College, 1984
Major in Psychology

WORK EXPERIENCE

1994 - present

Research Associate
University of Connecticut Health Center, Farmington, Connecticut
Responsibilities include the design, development, implementation, and evaluation of training materials and activities for early interventionists on collaboration.

1993 - 1994

Research Associate
University of Connecticut Health Center, Farmington, Connecticut
Responsibilities include the collection, coding, filing, entry and overall management of data collection protocol. Act as a liason with early intervention programs and personnel and the participating families.

1988 - 1993

Executive and Customer Service Manager
Tobacco Valley Sanitation, South Windsor, Connecticut
Established Customer Service Program involving data collection, survey development and analysis, interpretation of results, and direct contact with customer to determine needs. Developed and implemented recycling programs for all customer types including homes/families, schools, institutions (medical and educational), corporations, and municipalities which involved survey development, data collection and interpretation, training and implementation, follow-up visits and status reports of recycling projects and efforts. Direct sales contact with a variety of clientele (including individuals, corporate executives and medical personnel)

1986 - 1987

Corporate Communications Specialist
Aetna Life & Casualty, Hartford, Connecticut
Assisted in the development of advertising, public relations and marketing communications for insurance products and financial services. Created marketing strategy to promote the department's services within the company.

Executive Resources Consultant
Aetna Life & Casualty, Hartford, Connecticut
Assisted with programs examining management development issues affecting Aetna's executive population. Participated in all phases of ongoing research projects including data collection, data analysis and reporting of results.

1984 - 1985

Account Executive
Tobacco Valley Sanitation, South Windsor, Connecticut
Responsible for the establishment, maintenance and enhancement of current and prospective accounts in western Connecticut. conducted a feasibility study for the acquisition of a small company and handled the integration of that company's business into the operations of Tobacco Valley.

1984

Internship at Newington Children's Hospital
Assisted in developing learning, language and social skills of 15 boys (8-12 years of age). Included observation and direct testing/inquiry.

ASSOCIATIONS AND ACTIVITIES

- Vice President of The Graduate Business Association
- Founder and President of Kappa Kappa Gamma Fraternity Chapter at Trinity College
- Alumni Agent, Trinity College, Class of 1984
- M.B.A. Marketing Case Competition Team, University of Connecticut, 1987

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EDUCATION

Ph. D. Columbia University (Psychology) 1976

M. A. Columbia University (Psychology) 1974

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PROFESSIONAL EXPERIENCE

Project Evaluator, Division of Child and Family Studies, Department of Pediatrics, University of Connecticut Health Center. Responsible for evaluation of birth to three and early childhood education projects. Areas of responsibility include qualitative analysis of collaborative efforts toward inclusion and system change and quantitative analyses of service delivery costs. (present)

Consultant. Part-time work alone and in collaboration with small consulting firm, Connecticut Planning Associates, West Hartford, Connecticut. Projects include needs assessment, data system design and training for local governments. (1994)

Research Associate, Casey Family Services, Hartford, Connecticut. Associate in a small in-house research department of a private child welfare agency. Active in development and evaluation of new and existing programs including family reunification, long-term and specialized treatment foster care, and adoptive family assistance. Work closely with agency administration and workers on a goal directed approach to case planning and practice. Other research projects included workers' time use and placement decision making. (1989 - 1994)

Research and Intergovernmental Relations Officer, City of Allentown, Pennsylvania. Served as director of City's research bureau responsible for conducting and contracting research projects and as principal liaison with federal and state governments and national municipal organizations. Served as Acting Coordinator of Community Development Block Grant Program for one year (1988) in addition to regular responsibilities. (1983 - 1988)

Project Manager, Corporate Information Systems, FinanceAmerica (now Chrysler First), Allentown, Pennsylvania. Served as liaison between data processing department and several user departments. Promoted after six months from position of Procedures Analyst (technical writer). (1980 - 1983)

Research Analyst, Information and Research Department, City of Kansas City, Kansas. Responsibilities included evaluating and designing multi-user management information systems and conducting demographic analyses for City. (1977 - 1980)

Research Associate, Department of Psychology, University of Kansas. Assisted with research proposal on jury behavior and attitudes. (1977)

PUBLICATIONS AND WRITING

Program Development and Implementation

"Inside the Black Box: An Exploration of Service Delivery in a Family Reunification Program" (with E. Fein). *Child Welfare*, 1994, 73(3), 195-211.

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Research Methodology and Practice

"Methodological Issues in Studying Sibling Placements" (with E. Fein and D.B. Johnson). *Social Work and Research Abstracts*, 1993, 29, 2, 35-37.

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"Sibling Placement Pattern" (with E. Fein). *Common Ground*, 1991, 7(1), 3.

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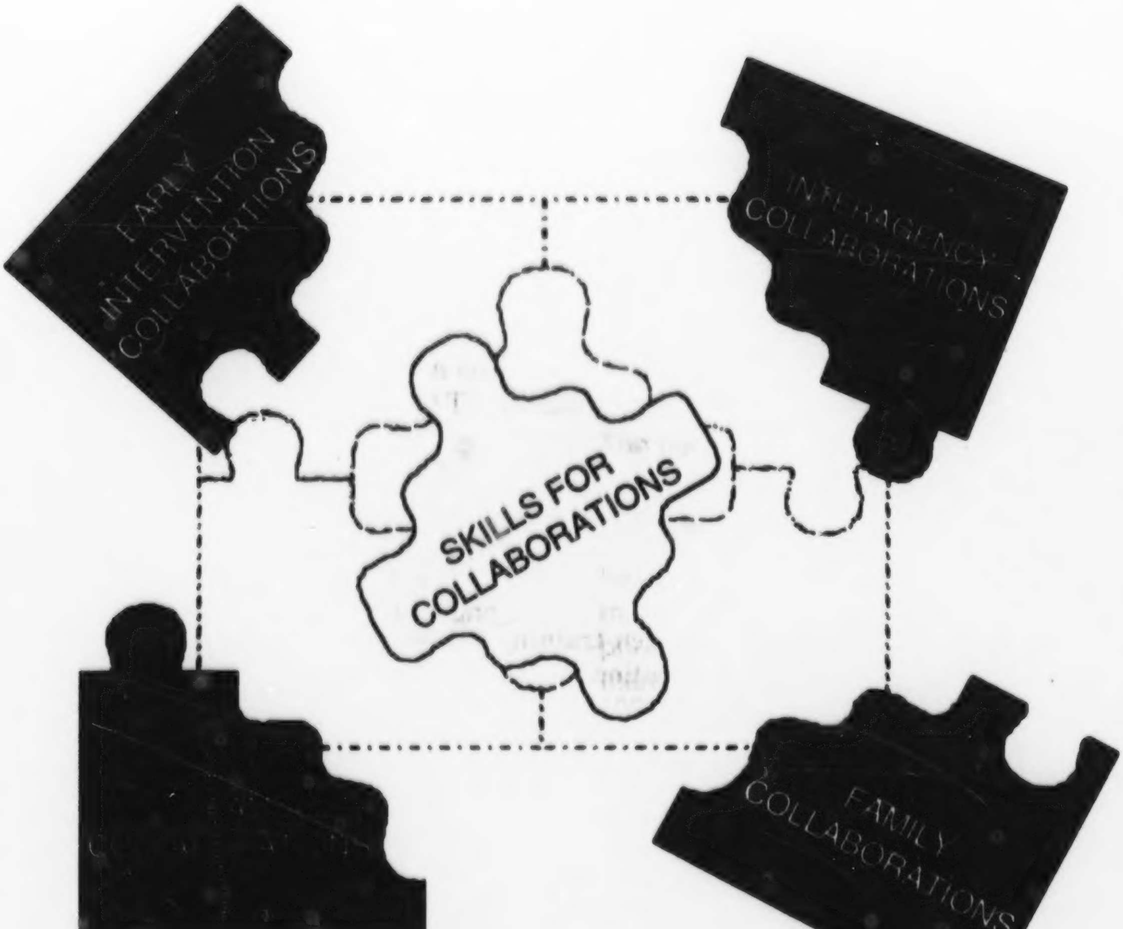
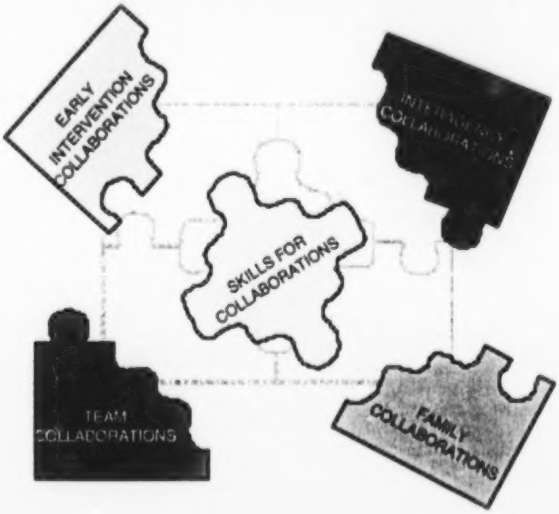
"Substance Abuse and Domestic Violence" (with E. Fein). *Common Ground*, 1990, 6(1), 13.

APPENDIX B

Collaboration: Putting the Puzzle Pieces Together


EARLY INTERVENTION COLLABORATIONS
INTERAGENCY COLLABORATIONS
SKILLS FOR COLLABORATIONS
FAMILY COLLABORATIONS

Collaboration: Putting the Puzzle Pieces Together


EARLY INTERVENTION COLLABORATIONS
INTERAGENCY COLLABORATIONS
SKILLS FOR COLLABORATIONS
TEAM COLLABORATIONS
FAMILY COLLABORATIONS

INTRODUCTION

Collaboration is a challenging, yet important goal for the field of early intervention. As the number of children who are eligible for early intervention grows, it is imperative that service providers and agencies learn to work together to maximize the available resources for service delivery.

The purpose of this manual is to highlight the important aspects of the collaborative process for early intervention. The analogy of a puzzle has been used in the layout of the manual because the underlying principles as presented in each of the manual's modules are essential for successful early intervention collaborations.

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Module One: Early Intervention Collaborations

provides an overview of the history of early intervention and the legal statutes that define early intervention. Within these statutes, are the program requirements that underscore the importance of collaboration in early intervention services and the coordination that must accompany services delivered by multiple agencies.

Module Two: Interagency Collaborations

describes the ways in which agencies can share the responsibilities of providing services to the same audience. The module acknowledges the barriers to the collaborative process, offers some strategies for overcoming these barriers, and discusses the process of building collaborative relationships.

Module Three: Family Collaborations

introduces the concept of family-centered care as the foundation necessary for any collaborative relationship that provides services to children. Through the framework of the Individualized Family Service Plan (IFSP), legislators mandated that services be available to infants and toddlers and their families. The family-centered IFSP ensures that appropriate services are available to the infant or toddler and his or her family members by acknowledging the leading role the family plays in the IFSP process.

Module Four: Team Collaborations

discusses the different ways early intervention service providers can work together with the family to provide an early intervention program for the child. The effectiveness of the program strongly relies on the abilities of the service providers and family members to function as a team. This module covers the factors that affect the development and maintenance of the team, as well as strategies for overcoming barriers to the team process.

Module Five: Skills for Collaborations

presents the service provider with the tools necessary to participate in a collaborative early intervention service delivery system. Specifically, the module focuses on the importance of communication, trust building, and negotiation.

Collaborations must occur among families, service providers, and agencies. To help illustrate the key concepts of the collaborative process, the manual presents a family story of a little girl, Polly, who receives early intervention services. At the end of each module, you will be asked to apply the concepts to Polly's service delivery program. These activities are designed to demonstrate the effort that a collaborative relationship requires, as well as the difference a collaborative relationship can make to a family and child.

Polly's Story

Polly is 18 months old and lives with her family in central Connecticut. She was born prematurely at a tertiary care hospital, the sole survivor of a set of triplets. Polly was hospitalized for 13 months following birth. Her medical and developmental conditions include:

- Brain damage that resulted from spinal meningitis
- Hydrocephalus, an enlargement of the head due to a buildup of fluid within the brain (A shunt has been surgically inserted to drain excess fluid from the cranial area.)
- Episodes of congestive heart failure
- Frequent infections that result in hospitalization
- A dependency on oxygen
- Self-abusive episodes, including severe head banging

As a result of these conditions, Polly and her family have been receiving a variety of services since she has been home, including:

- Health care through her primary pediatrician
- Occupational therapy once a week
- Speech therapy once every other week
- Physical therapy once a week
- Home education through a regional education service center (RESC) twice a week
- Sixteen hours per day of home nursing care
- Medical supply vendors for special formulas and oxygen
- Specialty care at a variety of clinics at the tertiary care hospital

Numerous professionals visit Polly and her family at their home on a regular basis. During the five months that Polly has been home, she has received services from five therapists, two teachers, ten nurses, and a hospital-based team composed of a physician, two nurses, a psychologist, a full range of therapists, and a social worker. Also assigned to her "case" are two social workers, three program supervisors, and three service coordinators from three separate agencies.

It is not surprising that Polly's parents are often caught in the middle of conflicts among the various professionals, each of whom seems to have a different opinion about Polly's needs, appropriate treatments, payment options, and service schedule. For example, the family has three case managers. Each manager gave the family different information about eligibility for various public sources of funding, including the Medicaid waiver. As a result, the family's application for benefits was delayed and they had to pay several thousand dollars out-of-pocket for Polly's cost of care. Additionally, the nursing agency and the various therapists disagree about the amount of therapy Polly needs, resulting in a lack of cooperation between the agency and therapists. Consequently, Polly's parents feel that the services she receives often cause confusion in their lives. The schedule for a typical week in their house looks like this:

Monday: 16 hours - nursing, teacher, supervisor, Department of Income Maintenance (DIM) case manager

Tuesday: 16 hours - nursing, occupational therapy, Department of Mental Retardation case manager

Wednesday: 16 hours - nursing, teacher, clinic visit at tertiary hospital, physical therapy

Thursday: 16 hours - nursing, physical therapy, vendor delivery, nursing supervisor, teacher

Friday: 16 hours - nursing, speech therapy, adaptive equipment fitting at tertiary care hospital

Saturday: 16 hours - nursing

Sunday: 16 hours - nursing

Polly's parents have concluded that caring for her is not the primary cause of their stress. Instead, they attribute it to the multiple layers of fragmented services that has created so much havoc within their family. They are now seeking out-of-home placement for Polly because they feel that they need to restore order back into their lives. Neither feels "functional" with so many people in and out of their home. In Polly's case, one of the purposes of P.L. 99-457 (to reduce the likelihood of institutionalization) has not been realized.

Helping Polly Through Collaboration

Polly is typical of many infants and toddlers who have multiple disabilities. The parents of these children usually interact with a variety of agencies and programs in order to meet the unique intervention needs of their child. Unfortunately, when trying to gain access to these services, parents are often confronted with a multitude of incomprehensible acronyms and an unwieldy maze of agencies that differ in priorities, mandates, geographic boundaries, and administrative structures.

The needs of infants and toddlers with disabilities have also created many challenges for service providers. Both federal legislation and recommended practice mandate that early intervention programs be family-centered, comprehensive, community-based and coordinated. State and local service agencies are presently struggling to develop such programs.

Most often, early intervention programs for infants and toddlers with disabilities consist simply of those services that are readily available. While the program may meet the needs of some families, other families may require a number of additional services that may be more difficult to access. This is especially true for those families who have children with multiple needs. For example, Polly's needs require her to participate in a hospital follow-up clinic, hospital- and home-based therapy, home health services (including equipment maintenance), and intervention program services from three agencies. These services are all limited in the type, frequency, and location of their delivery, and this dictates the options (or lack thereof) available to Polly's family. Additionally, the agencies providing the services have different goals, orientations, funding sources, and continuing eligibility requirements that further limit the availability of services.

Although it is clear that few agencies have the resources to provide a continuum of services to deal with all of the issues that may affect an infant or toddler with disabilities and his or her family, services must be restructured in such a way as to maximize coordination and enhance, rather than inhibit, family functioning.

When examining the unique services required by Polly and her family, the immediate challenge is to identify the various agencies, professionals, and payment sources currently involved in the provision of early intervention services in the community. While interagency and multidisciplinary coordination may be the first step toward alleviating some of the stress that Polly's family experiences, the ultimate goal should be the collaborative development of an individualized family service plan (IFSP) to be carried out under the direction of the family. There are two keys to this goal: family-centered services and collaborative service delivery. The purpose of this manual is to discuss the collaborative relationships required by Part H of IDEA, and, in particular, the family-centered and multidisciplinary interagency aspects of service provision.

EARLY INTERVENTION COLLABORATIONS

Early childhood is an important time in any person's life. For children with disabilities, the early years are critical for a number of reasons. First, the earlier a child is identified as having a developmental delay or disability, the greater the likelihood that the child will benefit from intervention strategies. Second, families benefit from the support given to them through the intervention process. Third, schools and communities benefit from a decrease in costs because more children come to school ready to learn.

As a field, early intervention has been defined as the provision of educational or therapeutic services to children under the age of eight. Legislatively, "early intervention" is used to describe the years birth to three, while the term "early childhood special education" or "preschool special education" refers to the period of preschool years (ages three through five). This manual will use the term "early intervention" as a description of services provided to children from birth to age three under the Individuals with Disabilities Education Act, Part H.

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Historical Perspective on Early Intervention

The history of early intervention spans multiple disciplines and fields of study. For example, the child development literature has provided early intervention a theoretical focus that has evolved from the transactional model of development. At one time, child development theory was polarized into two competing schools of thought: a biologically based view of development versus one that stressed behavioral and environmental factors. The transactional developmental theory represents a synthesis of the two theories: it emphasizes the interactive nature of child development.

The transactional model of development recognizes the fact that the interaction between the child and the environment is a continual process in which neither the child's status, nor the environmental effects on that status can be separately addressed. This developmental model suggests that the environment can be used to modify a child's biological limitations, and conversely, a deficient environment can lead to delays in a child's development. This focus has greatly influenced both early intervention strategies and early intervention service models, most notably on the emphasis placed on a child's relationship with his or her caregiver.

The maternal and child health field has emphasized the role of government in designing and supporting practices to promote the well being of children. The Children's Bureau, which was established by Congress in 1912, collected data on such issues as institutional care, mental retardation, and the care of crippled children. These data resulted in the funding of a national network of Maternal and Child Health centers and an increase in public health nursing.

In 1930, the White House Conference on Child Health and Protection recommended that programs for crippled children be made available in each state. The Social Security Act, enacted in 1935, established Maternal and Child Health Services, as well as services for "crippled children." Lastly, the Social Security Act amendments in 1965 included Medicaid services for children. In particular, the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program was initiated for all children under age 21 who qualified for Medicaid. EPSDT was funded to assist in the early identification and treatment of children's health and developmental needs.

Activity 1.1

List the agencies in your state that utilize MCH funds.

The field of early childhood education was also an important contributor to current early intervention service models. Initially, early childhood programs were developed to serve poor children and the parents of poor children. The concept of kindergarten was established in the early 1800's by proponents such as Friedrich Froebel in Germany, who emphasized the importance of play and learning for young children. The first public school kindergarten program was established in the United States in 1872. At the turn of the century, half of all kindergartens in the U.S. were operated by public school systems, although the major focus was on the potential benefits of such programs for children who were poor.

The concept of preschool or nursery school was firmly established in the early 1900's, and, as with kindergarten, the concept was developed in Europe. In England, the MacMillan sisters began nursery schools to provide for the emotional and physical well-being of poor children. Their focus was on the development of self care, responsibility, and educational readiness skills. In Rome, Maria Montessori also established early education programs for poor children. She had initially worked with children who were mentally retarded and used educational practices that emphasized learning through active involvement with the environment.

In the United States, both the Depression and World War II resulted in the government providing assistance to expand early education (both day programs and kindergarten) opportunities for young children, primarily as a support for working mothers. However, between 1946 and the Kennedy Administration (1960-63), early childhood programs remained stagnant. President Kennedy expanded the nation's commitment to early care by supporting legislation and appropriations to assist working mothers.

The largest government funded early childhood program, Head Start, was established in 1965. Head Start began as a compensatory program for four-year-old and five-year-old children from low income families. The program provided comprehensive early childhood services focusing on health, education, social services, and parent involvement. Other compensatory programs for young children were funded by a variety of legislative initiatives, many of which remain in effect today. For example, the Community Coordinated Child Care Program was established to improve all early childhood programs financed by federal funds. Unfortunately, this effort was inadequately funded, but it represented an initial attempt by the federal government to coordinate federal initiatives for young children.

Most recently, the federal Family Support Act (1988) and the Child Care and Development Block Grant (1991) recognized the importance of early care and education programs. States are authorized to coordinate such programs to ensure accessibility by families in need of child care, Head Start, and other children's services. Rather than draw a distinction between nursery school, compensatory programs, and child care, proponents have recently recommended the development of integrated systems of early care and education. However, fragmentation of services and dwindling resources continue to hamper efforts to build capacity and to enhance the quality of early childhood education so that all children may benefit from such programs.

Activity 1.2

List agencies in your state that receive either Head Start or Child Care and Development Block Grant funds.

Lastly, the field of special education contributed to the development of early intervention through its emphasis on remedial and compensatory services and instructional techniques. Special education history began in the late 1700's in France with the story of Victor, a child who had grown up with wolves. Jean-Marc Itard developed and provided an intensive education program to teach Victor (who was known as the "Wild Boy of Aveyron") language and behavior skills. His success led a student of his, Edourd Sequin, to develop a physiological method to educate children with disabilities. This method emphasized the importance of early education and the use of detailed assessment information from which to develop a remediation plan. Unfortunately, the techniques used by Itard and Sequin were not universally adopted, and the preferred treatment for people with disabilities during the 1800's in both Europe and the United States was institutionalization and segregation from society.

People with disabilities received more benevolent attention after World War II, partly because of the number of injured veterans who returned home with rehabilitation needs. A Section for Exceptional Children was established within the U.S. Office of Education in 1946. As rehabilitation services became more plentiful, parents of children with disabilities organized into advocacy groups to increase the availability of services to their children. Many advocacy organizations became developers and providers of preschool services.

During the Kennedy Administration (1960-1963), the government became more involved in providing services to children with disabilities. This commitment was formalized by Congress in 1966 when the Section for Exceptional Children was expanded to the Bureau of Education for the Handicapped within the U.S. Office of Education. A number of legislative initiatives also began in this era, including the 1968 Handicapped Children's Early Education Assistance Act. The act provided federal funds to support model demonstration programs to educate infants and preschool-age children with disabilities. This impetus began to raise awareness about the importance of early intervention and an early childhood branch was developed in the Office of Special Education and Rehabilitation Services within the U.S. Department of Education. It was not until 1986 however that a federal mandate was established to make special education services available to all preschool-age eligible children with disabilities. This mandate was established as P.L. 99-457, a set of amendments to P.L. 94-142, the Education of All Handicapped Children Act (later renamed the Individuals with Disabilities Education Act, or IDEA).

IDEA mandated a free appropriate public education to all school-age children with disabilities. P.L. 99-457 then added to IDEA a number of significant components specific to children under age five. First, services for eligible young children (ages three through five) were mandated under the provisions of free appropriate public education (Part B of P.L. 94-142). Second, these amendments created incentives for states to develop an early intervention entitlement program for children from birth through age two (Part H). Through IDEA's Part H, Congress identified an "urgent and substantial need" to enhance the development of infants and toddlers with disabilities, to minimize the likelihood of institutionalization and the need of special education services after this group reaches school age, and to enhance the capacity of families to meet the special needs of their infants and toddlers with handicaps (Education of the Handicapped Act Amendments of 1986, Section 671). To meet this need, federal financial help was made available to the states to develop programs to deliver interagency, multidisciplinary services for all eligible children. Table 1-1 contains a listing of the system components each state had to have in place in order to qualify for Part H federal funds. As of 1995, all U.S. states and territories were participating in Part H services.

Table 1-1: Early Intervention System Components

1. A state definition of the term "developmental delay."
2. A timetable to ensure services.
3. A multidisciplinary evaluation of each eligible child.
4. An IFSP, including service coordination, for each eligible child and family.
5. A comprehensive child find campaign.
6. A public awareness system.
7. A central directory of services and other resources.
8. A comprehensive program of personnel development.
9. Designation of a single line of responsibility in the lead agency.
10. A policy on contracting with local service providers.
11. Procedures for timely reimbursement of funds.
12. Procedural safeguards.
13. Policies for personnel standards.
14. A system for compiling data.

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Activity 1.3

Describe how each of the 14 components are being implemented in your state.

COMPONENTS	IMPLEMENTATION STATUS
1. A state definition of the term "developmental delay."	
2. A timetable to ensure services.	
3. A multidisciplinary evaluation of each eligible child.	
4. An IFSP, including service coordination, for each eligible child and family.	
5. A comprehensive child find campaign.	
6. A public awareness system.	
7. A central directory of services and other resources.	
8. A comprehensive program of personnel development.	
9. Designation of a single line of responsibility in the lead agency.	
10. A policy on contracting with local service providers.	
11. Procedures for timely reimbursement of funds.	
12. Procedural safeguards.	
13. Policies for personnel standards.	
14. A system for compiling data.	

Program Requirements

Part H of IDEA recognized the fact that no single agency or service provider has all of the knowledge and skills necessary to meet the multiple needs of families participating in early intervention. Many of the provisions of the law require both coordination and collaboration at the local, state, and federal levels. For example, states that are participating in the federal program must initiate a number of collaborative planning and implementation activities. Among these are:

- ***The establishment of a statewide interagency coordinating council (ICC) composed of parents and representatives from relevant state agencies and service providers.***

  The reauthorization of P.L. 99-457 requires that these councils consist of between 15 and 25 members and that the chair *not* be from the lead agency. Councils may vary in how many agencies are represented; at least 20% of the membership must be parents however.

- ***The maintenance of a lead agency for general administration, supervision, and monitoring of programs and activities, including responsibility for carrying out the entry into formal interagency agreements and the resolution of disputes.***

  Approximately 21 states have chosen the Department of Education as their lead agency; others have chosen their Department of Health or Department of Developmental Disabilities or Mental Retardation.

- ***The development of interagency and multidisciplinary models of service delivery for eligible infants, toddlers, and their families as specified in the IFSP, which is directed by the family.***

  "Multidisciplinary" has been further defined by the U.S. Department of Education to mean efforts involving persons representing at least two professional disciplines.

- ***The appointment of a service coordinator to facilitate and ensure the implementation of the IFSP.***

  The service coordinator is responsible for the implementation of the IFSP and for ongoing coordination with other agencies and individuals to ensure the timely and effective delivery of services. Part H of

IDEA does not designate any single professional to assume this role. In fact, the recent reauthorization acknowledges the rights of family members to fill this role (for themselves or others), if they obtain "appropriate training." The legislation defines the duties of the service coordinator as follows:

to assist and enable an eligible child and the child's family to receive the rights, procedural safeguards, and services that are authorized under the state's early intervention program. Service coordinators are responsible for coordinating all services across agency lines and serving as the single point of contact in helping parents to obtain the services and assistance they need (34 CFR §303.22).

Activity 1.4

Which of the four collaborative activities described above seems to be the most challenging to you? Why?

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Which of the collaborative activities seems to be the easiest? Why?

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Background on Service Coordination

The recognition of the need for service coordination stems from previous experience in social work and nursing. Professionals in these fields often worked in the capacity of managing a number of agency representatives that had an impact on the day-to-day functioning of people with developmental disabilities, mental illness, or complex medical needs. As a result, social workers and nurses may receive more training than others in the competencies necessary for service coordination. The demands of the early intervention system, however, require that members of each discipline involved in service delivery receive adequate preparation to fulfill both the spirit and intent of the law.

The regulations of Part H of IDEA do not establish discipline-specific requirements for service coordinators. Rather, the general qualifications are the knowledge of:

- early intervention legislation on state and federal levels.
- infants and toddlers with disabilities.
- available resources.
- procedural safeguards available to families.

The role of service coordinator is critical to the implementation of the family-centered philosophy of the law. Rather than act on behalf of families, or as a restraint on optimal service provision, the service coordinator must facilitate the true intent of the law: to support families in their caregiving role. Service coordination must occur within a collaborative problem-solving partnership between the coordinator and the family. The overall process includes the following activities:

(1) coordinating the performance of evaluations and assessments; (2) facilitating and participating in the development, review, and evaluation of IFSPs; (3) assisting families in identifying available service providers; (4) coordinating and monitoring the delivery of available services; (5) informing families of the availability of advocacy services; (6) coordinating with medical and health providers; and (7) facilitating the development of a transition plan to preschool services, if appropriate.

In a coordinated system, the family and child actively participate in a productive and constructive process that views the infant or toddler from his or her family's perspective; this is the ultimate goal of effective service coordination and collaborative service delivery. For this reason, service coordinators must have excellent interpersonal, communication, negotiation, and facilitation skills.

Activity 1.5

What steps/actions could a service coordinator take to make sure family-centered, comprehensive, coordinated services are being delivered?

Inherent in these provisions is the concept of a statewide system of coordinated, comprehensive, multidisciplinary, interagency programs of early intervention services for infants and toddlers with disabilities and their families. This concept requires commitment by all service agencies and providers to cooperatively and collaboratively plan, implement, and evaluate services that enhance the capacity of families to meet the special needs of their children. Clearly, the challenge to the service delivery system is to develop new interagency and multidisciplinary models of early intervention that meet the intent of the law, and, most importantly, the needs of families such as Polly's.

Activity 1.6

Now think about Polly's story. Does her service delivery plan meet the intent of the laws governing early intervention?

Specifically state the aspects of her service delivery that are not compliant.

Notes

INTERAGENCY COLLABORATIONS

Collaboration is a term used to describe efforts to unite people, professionals, programs, or agencies for the purpose of achieving common goals that could not be accomplished by an agency or individual working alone. Infants and toddlers with disabilities and their families have needs that are diverse, interrelated, and vary over time. No single agency or service provider has all of the skills necessary to meet the needs of a child with disabilities and his or her family. Service agencies and providers must work together to plan, implement, and evaluate services that enhance a family's ability to meet the special needs of the child. In order to do this, collaborations must occur within all levels of service delivery, beginning at the agency level.

There are three ways agencies and service providers can come together to serve young children with disabilities: they can ***cooperate, coordinate, and collaborate***.

Cooperation

Cooperation is the first step in developing an effective service delivery system. It is characterized by people, programs, and agencies informally sharing information (e.g., brochures, mailing lists, newsletters, and trainings) to achieve day-to-day goals. Cooperation does not require groups to be interdependent or interactive in terms of their formal policies, procedures, or activities. For example, an early intervention service provider cooperates with family members by sharing information with them regarding their child's disability, the child's specific developmental needs, and the services available to meet those needs.

Coordination

When people begin to realize that they share similar responsibilities, they are ready to take the next step toward effective service delivery: coordination. Coordination is characterized by people, programs, and agencies formally defining their roles and responsibilities. This can result in the elimination of any gaps or duplication in the service delivery system. Like cooperation, coordination requires agencies to share information and resources, but on a more formal level. For example, as groups begin to coordinate activities, they begin to look at their policies in terms of sharing information and resources, but there are no formal changes in the any particular agency's policies, procedures, and goals.

Collaboration

When groups come together formally to achieve a common goal, they are collaborating. Collaboration is the process of people, programs, and agencies coming together to define their policies, procedures, and activities in an effort to achieve a common goal. The focus of the collaborating group is to jointly find a solution to a given problem. Collaboration requires shared decision making, resources, and power. ***The key to collaboration is the realization that no one alone has all the power, resources, and expertise to deliver the most effective services possible.*** By giving up traditional roles and coming together, the group members can maximize their skills and knowledge to create a more effective service delivery system.

No single agency or service provider has all the skills and knowledge necessary to meet the multiple needs of a child with disabilities and his or her family.

Activity 2.1

Collaboration involves people from different agencies or programs coming together for the purpose of implementing an effective early intervention program for a child with disabilities and his or her family. List some benefits of collaboration for agencies, service providers, and families.

Benefits to Families	Benefits to Service Providers	Benefits to Agencies

Early Intervention Service Delivery

The degree to which each agency or service provider works together with others determines the nature of the service delivery. The development of cooperative arrangements for the purpose of service delivery is a common strategy that is used for program improvement. Cooperative arrangements are required by many federal laws, and the desired outcome is the development of an interagency cooperative agreement. However, cooperative arrangements rarely result in improved services. This is because cooperating agencies and service providers maintain their own autonomy, as well as their own philosophy and service goals, which may not be appropriate for the target population. Unfortunately, this model tends to drive most initial attempts to organize services for young children with disabilities and their families.

In order to improve this situation, it has been suggested that the focus of early intervention should shift from cooperative arrangements among agencies and providers to collaborations focused on joint service delivery. A collaborative strategy is appropriate in communities where the need and intent is to make a fundamental change the way services are designed and delivered. This requires that the involved agencies and service providers agree on a common philosophy and service goal that can be achieved only through joint agency activities. ***Collaboration is the key to effective early intervention.***

Unfortunately, the development of collaborative early intervention service systems remains an elusive goal for many states. This is not surprising considering that the service delivery system is composed of independent agencies, institutions, and organizations, and each provide a specific service or function. As a result, each participating service provider has his or her own orientation toward the service system. For example, hospitals and health professionals view early intervention very differently from community oriented agencies and professionals. However, Part H of IDEA mandates that many agencies work together to create joint activities focused on the development of collaborative, early intervention services.

Activity 2.2

List the agencies, programs, and services (both public and private) that are available to families with infants and toddlers in your community.

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Barriers to Collaboration

Table 2-1 identifies some common barriers to successful collaborations. The following are some of the most common:

Competitiveness Between Agencies and Providers

One barrier to collaboration is competitiveness. Competition between agencies and providers for clients and services often exists. Frequently, conflicts result from a lack of accurate information about the functions of other agencies or providers. Agencies and service providers must be prepared to share information with each other so that barriers to interdependent functioning can be identified and removed. Many existing agency and program policies will need to be evaluated and refined in order to develop collaborative service delivery models.

Table 2-1: Common Barriers to Collaboration

COMPETITIVENESS BETWEEN AGENCIES AND PROVIDERS

- Turf Issues
- Lack of Information About Other's Functions
- Political Issues

LACK OF ORGANIZATIONAL STRUCTURE FOR COORDINATION

- Differing Philosophies
- Independent Goals
- Haphazard Team Process
- Lack of a Facilitator
- Lack of Monitoring and Evaluation Process
- Lack of Planning
- Lack of Power and Authority to Make and Implement Decision

TECHNICAL FACTORS

- Resources: Staff, Time, Budget
- Logistics: Distance, Geography

PERSONNEL

- Parochial Interests
- Resistance to Change
- Staff Attitudes
- Lack of Commitment to Community Needs
- Questionable Administrative Support
- Discipline Specific Jargon and Perspectives

Lack of Organizational Structure for Collaboration

Another collaboration barrier results from a lack of an organizational structure to facilitate coordination between agencies and providers. Traditionally, the goals and philosophies of each agency and service provider are individually established. Therefore, existing agency structures may not

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be conducive to the collaborative planning and implementation of decisions in a cooperative and coordinated manner. The first step in creating a collaborative arrangement is the adoption of a common vision by all involved in the service delivery system. One difficulty in establishing a shared vision may be the existence of differing interpretations of the adequacy of the existing system. This obstacle can only be overcome when all participants are willing to share in a process to ensure open, continued communication, negotiations, and conflict management.

Technical Factors

Technical factors also interfere with service delivery collaboration. Scarce resources of staff, time, and money are factors that inhibit agencies from exerting the time and effort to collaborate with other agencies. In an age of shrinking resources, collaborations are often the only way to guarantee the development of an integrated service system. Logistical issues, such as a distance and geography, are also common excuses for agencies to not work collaboratively.

Personnel

The attitudes of personnel can present the greatest barrier to collaboration. Individuals who resist change will find many reasons why collaboration between agencies and providers cannot occur. Frequently, such resistance indicates of a lack of commitment to the more global needs of children and families, a failure to acknowledge the strengths of other disciplines, or a lack of support from administrative powers. The people involved in the creation, development, and implementation of the collaborative service system are a critical factor in the ultimate success of such a model. Most important is an effective leader. A leader must be able to both establish and "sell" the vision to all participants. He or she also must be able to translate the vision into the reality of service delivery. Also important is the competence and commitment of the other participants, in terms of both policymaking and service delivery. All participants should be provided access to support and training as their roles change with the development and implementation of a collaborative service delivery system.

Activity 2.3

From your own experience, list some examples of the common barriers to the development of collaborative early intervention systems.

Interagency Collaborations

A collaborative service delivery model requires a new structure in which agencies give up some of their autonomy in order to provide optimal services to children and their families.

Under Part H of IDEA, interagency collaboration for the purpose of the design and delivery of early intervention services must occur at both the state and community levels. Ideally, these collaborations will be closely aligned and allow for comprehensive service provision that benefits families and children.

Activity 2.4

How do the agencies that provide early intervention services in your community collaborate?

Though collaboration may not always be possible, it is certainly the most desirable style for professionals from various agencies to use to interact with one another. A more favorable climate for collaboration occurs when agencies, programs or groups share a common philosophy and goal, and the service delivery issue is a priority for each of the service agencies. However, there are several barriers to implementing interagency collaboration. For example, not all participating agencies may agree on the necessity for service improvements. There may be other priorities influencing agencies, such as a budget shortfall, or a history of competition or negative relationships among participants. Nevertheless, federal legislation (Part H of IDEA) for early intervention has clearly created a need to prioritize collaboration, which should facilitate the development of a favorable climate for change to occur.

Activity 2.5

Use the following checklist to assess the status of interagency coordination for early intervention in your community. The checklist has five dimensions of interagency coordination and characteristics that describe each. These characteristics may have a positive or negative influence on interagency collaboration. Please indicate the kind of influence each characteristic has on your interagency group.

Scale:	+5	4	3	2	1-
	Positive	Somewhat Positive	Neutral	Somewhat Neutral	Negative

CLIMATE

1.	Past experience in interagency coordination	+5	4	3	2	1-
2.	Decision makers who have worked together over time	+5	4	3	2	1-
3.	Trust level among key individuals	+5	4	3	2	1-
4.	Attitude of key decision maker	+5	4	3	2	1-
5.	Support of key decision makers	+5	4	3	2	1-
6.	Local relationship with state level agency	+5	4	3	2	1-
7.	Interagency cooperation is a priority of program staff	+5	4	3	2	1-
8.	Program goal is priority of the community	+5	4	3	2	1-
9.	Past experience in program area	+5	4	3	2	1-
10.	Delineation of agency roles and responsibilities	+5	4	3	2	1-

RESOURCES

11.	Availability of financial resources	+5	4	3	2	1-
12.	Availability of personnel	+5	4	3	2	1-
13.	Quality of personnel	+5	4	3	2	1-
14.	Some program components already in place	+5	4	3	2	1-
15.	Funds budgeted to support coordination	+5	4	3	2	1-
16.	Time available for coordination efforts	+5	4	3	2	1-
17.	Availability of options for referral of services	+5	4	3	2	1-
18.	Coordination among resources to avoid gaps and duplication	+5	4	3	2	1-

POLICIES

19.	Existence of federal policies	+5	4	3	2	1-
20.	Existence of state policies	+5	4	3	2	1-
21.	Federal and state policies are clear and understandable	+5	4	3	2	1-
22.	Consistency between state and federal policies	+5	4	3	2	1-
23.	Existence of local policies or guidelines	+5	4	3	2	1-
24.	Consistency between local policies or guidelines and federal and state policies	+5	4	3	2	1-
25.	Existence of local interagency agreements	+5	4	3	2	1-
26.	Definitions of the roles of coordinating agencies	+5	4	3	2	1-
27.	Existence of state level interagency agreements	+5	4	3	2	1-

PEOPLE

28.	Key person(s) provides leadership in acceptance of a shared vision	+5	4	3	2	1-
29.	Key person(s) whose influence crosses agency boundaries	+5	4	3	2	1-
30.	Key person(s) provides leadership in planning and program implementation	+5	4	3	2	1-
31.	Staff have skills in human relations, negotiation, conflict resolution	+5	4	3	2	1-
32.	Staff have diverse skills from various disciplines	+5	4	3	2	1-
33.	Staff recognize the importance of interagency cooperation	+5	4	3	2	1-
34.	Interagency cooperation is a priority of program staff	+5	4	3	2	1-

PROCESSES

35.	Existence of a formal systematic planning process	+5	4	3	2	1-
36.	Existence of a formal communication process (regular meetings, newsletters, policy bulletins, etc.)	+5	4	3	2	1-
37.	Existence of an informal communication network (personal/professional relations)	+5	4	3	2	1-
38.	Existence of a dispute resolution mechanism	+5	4	3	2	1-
39.	Use of participatory planning using all relevant stakeholders	+5	4	3	2	1-

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Harbin, G., Dahaher, J., Bailer, D., & Eller, S. (1991). Status of states' eligibility policy for preschool children with disabilities. Chapel Hill, NC: Carolina Policy Studies Program, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

Collaboration: Predictors of Success

There is no magic formula for developing interagency models, but a number of key ingredients have been identified. In particular, Melaville and Blank (1991) have identified the following five variables that shape an effective interagency collaborative system:

- ***The social and political climate for change.***

  A more favorable climate for collaboration occurs when the targeted service delivery issue is a priority for each of the service agencies.

- ***The processes of communication and problem solving.***

  Interagency collaborations rely on the adoption of a process to establish goals and objectives, clarify roles, make decisions, and resolve conflicts.

- ***The human dimension.***

  The people involved in the creation, development, and implementation of the interagency service system are a critical factor in the ultimate success of the collaborative model.

- ***The policies that support or inhibit interagency collaboration.***

  Each participating agency and program entering into an interagency collaboration has a set of rules and regulations which governs its mandate, target population, budgetary operations, and service structure (including staffing patterns). Agencies and programs must be prepared to identify and share these policies with each other so that barriers to interdependent functioning can be identified and removed.

- ***The availability of resources.***

  Interagency collaborative efforts require new fiscal arrangements to ensure the development and delivery of services. Resources of all kinds (fiscal, staff, time, in-kind services) will have to be pooled to establish the most efficient delivery of services. In an age of shrinking resources, interagency collaborations are often the only way to guarantee the development of an integrated service system. Early intervention is one area in which resources must be jointly pooled and funding levels must be increased. Only then will states be able to implement services in conjunction with the spirit of Part H of P.L. 99-457.

Activity 2.6

Using the five predictors, describe the conditions for interagency collaboration in your community's early intervention program/system.

The social and political climate for change.

The processes of communication and problem-solving.

The human dimension.

The policies that support or inhibit interagency collaboration.

The availability of resources.

In both cooperative and coordinative partnerships, the needs of the interagency effort are secondary to the needs of the single agencies. In a collaborative effort, the interagency effort is seen as a separate entity. As such, it has needs that parallel those of the individual agencies. Staff members must have loyalty to both the interagency program's goal and to their single agencies. Decision making authority rests with the interagency group, whereas in cooperative and coordinative efforts, decision making typically lies with the individual agencies. The interagency group needs to develop collaborative procedures that foster conflict resolution, enhance trust, determine the benefits to be derived from all participants, share information, and create an effective decision making mechanism.

The development of trust is essential in order for the interagency goal to be met. Consensus building only works when the participants trust that everyone is committed to the same objectives with no "hidden agendas," and when each single agency believes that it is getting enough benefits from the collaboration to justify the investment of resources that it is making. It is important for each agency to have the opportunity to discuss what it hopes to get out of the collaboration, and to have input into the design of processes and procedures for the management of the interagency unit.

> ***Barriers to a successful change process are related to external forces, motivation, leadership, and operational factors. Attention must be paid to these barriers to prevent the process from stalling out.***
>
> ***--Carl L. Hirshman and Steven L. Phillips***

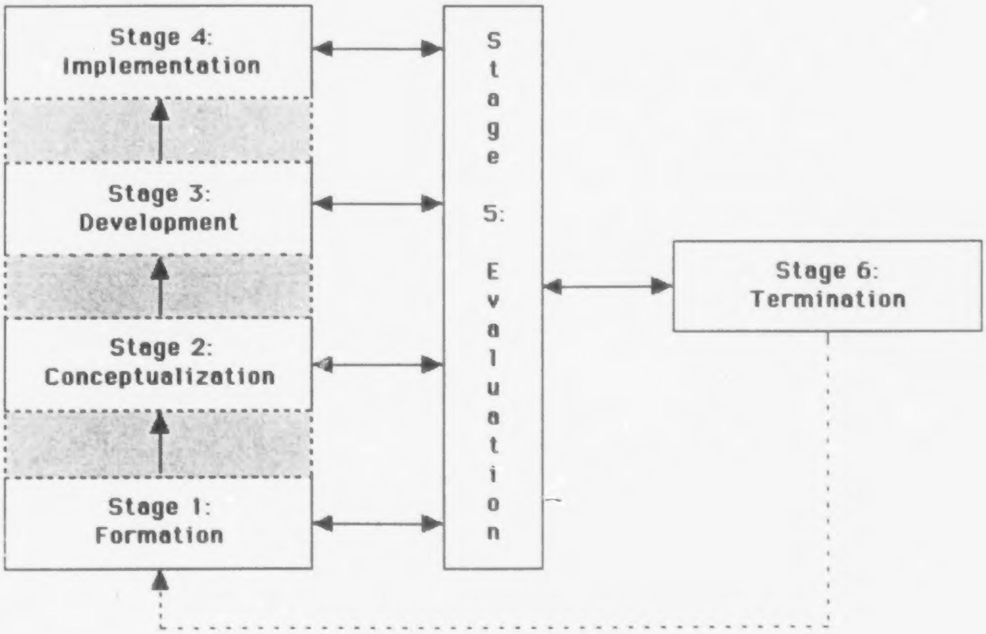
Activity 2.7

Draw an organizational chart of key early intervention players (agencies, task forces, committees, etc.) in your community. Next, identify strengths, opportunities, barriers, and strategies for effecting change within the organization.

The Development of Interagency Collaborations

There have been many theories put forth about organizational development, with a finite number of stages identified and described. Progression through these stages often appears linear, but in reality collaborative groups often find themselves overlapping some of the stages as they progress. Kagan (1991) outlines six stages in the life of an interagency collaborative process.

Kagan's Stages of Interagency Collaborative Process


Stage 4: Implementation
Stage 3: Development
Stage 2: Conceptualization
Stage 1: Formation
Stage 5: Evaluation
Stage 6: Termination

Formation

In this stage, someone initiates the idea of collaboration; it is the visioning stage. The vision arises in response to a potential or actual problem, and the initiating individual identifies others who then become stakeholders in the process. These stakeholders together explore the viability of the vision; they become acquainted with each other and their programs, partly to assess turf issues; and, they begin to identify a global mission.

Conceptualization

This stage begins when participants adopt a formal policy statement and objectives. They discuss each person's expectations and reasons for participating in the collaboration. They agree on a common purpose and direction. This is the stage in which tasks, roles, and responsibilities are delineated, and a decision-making model and administrative structure for future interagency activities are developed.

Development

Here a formal structure is developed that will sustain the interagency entity. The group identifies programs for revision or expansion, establishes a communication system, assigns work group tasks, and selects locales in which the work will take place. Issues and conflicts within the group are addressed and resolved, plans are formulated, and seek acceptance from the key decision-makers in their own agencies.

Implementation

This is the action-intervention stage, when the proposed revisions are put into place. Decisions are carried out at the administrative and service delivery levels. Policy changes are made to comply with decisions made in previous stages, agencies interact accordingly, and services are improved.

Evaluation

Evaluation in any collaborative venture is an ongoing process, and should be conducted continuously. The unit must always look at how accomplishments measure against expectations, and whether the vision is becoming a reality. Evaluative efforts should look at four dimensions: 1) the effectiveness of the process (i.e., the relationship between goals and actual results); 2) equity; 3) the adequacy of the effort, (i.e., were enough resources dedicated to the effort to achieve the desired results); and, 4) cost efficiency (i.e., was the maximum return achieved from the monetary investment).

Evaluation takes place at several levels simultaneously. The first is the level of the *client*: Is service delivery improving as anticipated? The second is the level of the *provider*: Is the job easier as a result of the collaborative effort? The third is the level of *administrators and funders*: Are costs reduced and waste eliminated?

Termination

Termination occurs when the collaboration is no longer needed -- either because the initial problem has been solved, or because the benefits of collaboration have failed to outweigh the costs. The end of one collaborative venture may precipitate the beginning of another, as systems and structures are scrutinized and new procedures are developed to meet the needs of a changing environment.

Activity 2.8

Describe an interagency group you may be involved with and try to determine which of the six steps you are focused on currently.

Activity 2.9

At which level are Polly's early interventionists working: coordination, cooperation or collaboration?

Describe the current barriers their team is experiencing.

Describe the benefits that Polly and her family would experience from a collaborative approach to service delivery.

Notes

FAMILY COLLABORATIONS

Every child is a member of a family (however it defines itself) and needs a home and a secure relationship with an adult or adults. These adults create a family unit and have ultimate responsibility for caregiving, supporting the child's development, and for enhancing the quality of the child's life. The caregiving family must be seen as the constant in the child's life, and therefore, the primary unit for service delivery. Early interventionists must respect the individual families they serve, and the decisions of these families in directing their children's early intervention programs.

Traditionally, families have been viewed as being comprised of a husband, wife and children, living comfortably together in their own home. However, this definition does not describe most families today. Anthropologists, sociologists, and other professionals who study people and their social relationships have struggled to answer the question, "What is a family?" Nearly every one of us has grown up in a family and has a sense of what a family is. Yet, it is extremely difficult to create a definition that includes all the variations of a "family."

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Activity 3.1

Take a few minutes to write your definition of a "family."

Now examine your definition and consider the following questions:

- Does your definition include single parents raising children?
- Does your definition include grandparents and foster parents raising children?
- Does your definition include extended family members?

The traditional concept of an "ideal family" can be harmful because the definition of a "traditional" family, which has a married mother and father living together with their children causes us to label families who don't fit this pattern as "abnormal." For example, single parents, unmarried adults raising children, or childless couples are often seen as social problems. Variations in the makeup of families are common. When non-traditional families are viewed as problems, we fail to recognize and respect a family's strengths. Secondly, only a small percentage of families today actually resemble the traditional family. In fact, according to the 1990 Census Data, only 37.2% of families living in the United States and 35.3% of families living in Connecticut fit the definition of the "traditional family".

An updated, more relevant definition of "family" was developed by a legislative task force on young children and their families in New Mexico. This definition describes the concept of family:

"We all come from families. Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents. We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a family by birth, adoption, marriage, or from a desire for mutual support. As family members we nurture, protect and influence one another. Families are dynamic and are a culture unto themselves, with different values and unique ways of realizing dreams. Together, our families become the source of our rich cultural heritage and spiritual diversity. Each family has strengths and qualities that flow from individual members and from the family as a unit. Our families create neighborhoods, communities, states, and nations."

No two families are exactly alike. Families differ in their size, their composition, and how they function. Most importantly, all families have strengths.

Parenting a Child with Disabilities

Parents of young children with disabilities rarely take on this parenting role with any preparation for the special challenges they will face. Rather, the early days, weeks and months of parental responsibility may be spent in a blur of visits to the hospital, physician's office and special clinics with little or no opportunity to adapt to the significant change that has taken place in their lives. While most parents report an increase in the level of stress they perceive after the birth of a child, the parents of an infant with disabilities must deal with unanticipated pressures and responsibilities that can make the parenting role appear to be overwhelming.

Parents traditionally have been an integral part of early intervention services. By far, their most significant role has been that of service provider or teacher of their child. The implementation of this parent role represents a somewhat restricted view of parent involvement. All too often, early intervention parent training programs have imposed intrusive demands and expectations on parents that have altered their interactional style with both the child with disabilities and the rest of the family.

The application of family systems theory has prompted the recommendation that early intervention programs move away from a narrow focus of the child and encompass the broader and self-identified needs of the enrolled parents. The primary goal of early intervention should be to facilitate the parents' awareness of, and adaptation to, their primary role of parenting a child with disabilities. One key to accomplishing this goal is to recognize the ongoing stress of parents and assist them to identify and recruit support networks. By changing the focus from child change to parent-family adaptation, both programs and parents will see beneficial results.

Family support strategies should be integral to any service delivery system for families with infants and toddlers who have disabilities. The support strategies should be both formal (e.g., assistance with insurance and financial needs; identification of respite services; training on medical equipment) and informal (e.g., identifying existing community resources; facilitating family involvement within the school). The overriding premise of such support is that it must be individually matched to the needs of the family, and the use of such strategies should be directed by the family.

The story, "A Trip to Holland," was written by a parent describing how she felt upon the birth of her child who was identified as having Down syndrome.

We must respect a family's priorities and support their choices, no matter how different from ours they may be.

A Trip to Holland

When you're going to have a baby, it's like you're planning a vacation to Italy. You're all excited seeing the Coliseum, the Michaelangelo, the gondolas of Venice. You get a whole bunch of guide books, you learn a few phrases in Italian, so you can order in restaurants and get around the town. When it comes time, you excitedly pack your bags, head for the airport, and take off for Italy. Only when you land, your stewardess announces, 'Welcome to Holland' You look at one another in disbelief and shock, saying 'Holland? I signed up for Italy.' But they explain that there's been a change of plans and the plane has landed in Holland, and there you must stay. 'But I don't know anything about Holland. I don't want to stay here,' you say. 'I never wanted to come to Holland. I don't know what you do in Holland, and I don't want to learn.' But you do stay, and you go out and you buy some new guide bocks. You learn some new phrases in a whole new language, and you meet people that you never knew existed. But the important thing is that you are not in a filthy, plague infested slum full of pestilence and famine. You are simply in another place, a different place than you'd planned. It's slower paced than Italy, less flashy than Italy, but after you've been there a little while and you have a chance to catch your breath, you begin to discover that Holland has windmills, Holland has tulips, and Holland even has Rembrandts. But everyone you know is busy coming and going to and from Italy, and they're all bragging about what a great a time they had there. And for the rest of your life you will say 'Yes, that's where I was going; that's where I was supposed to go; that's what I planned.' And the pain of that will never, ever go away. And you have to accept that pain, because the loss of that dream, the loss of the plan, is a very, very significant loss. But if you spend your life mourning the fact that you didn't get to Italy, you will never be free to enjoy the very special, the very lovely things about Holland.

--Emily Kingsley

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Activity 3.2

List family support services that are available in your community.

Family Centered Care

Family-centered care refers to a set of beliefs, attitudes, and principles that have been applied to the care of children with special healthcare needs and their caregiving families. The philosophy of family-centered care is based on the fact that the family is the enduring and central force in the life of a child, and has a large impact on his/her development and well-being. Table 3-1 contains a list of the principles of family centered care, and they are further described.

Table 3-1: Principles of Family-Centered Care

1. Acknowledge the family as the constant in a child's life.
2. Facilitate collaboration at all levels of care.
3. Share unbiased and complete information with family members about their child's care on an ongoing basis, and in an appropriate and supportive manner.
4. Implement appropriate, comprehensive services that provide emotional and financial support to meet the needs of families.
5. Recognize the family's strengths, individuality, and methods of coping.
6. Understand and incorporate the developmental needs of infants, toddlers, and families into everyday routines and activities.
7. Encourage and facilitate parent-to-parent support.
8. Assure that services are flexible, accessible, and responsive to the family's needs.
9. Honor the racial, ethnic, cultural, and socioeconomic diversity of families.

- ***Acknowledge the family as the constant in a child's life.***

  Early intervention is part of a child's life for a relatively short period of time. It is essential to recognize and respect the central and lasting role the family plays in the child's life.

- ***Facilitate collaboration at all levels of care.***

  Successful intervention depends on the ability of families and early intervention service providers to work together as partners. It is important to respect the skills, abilities, knowledge, and individual dreams of families.

- ***Share unbiased and complete information with family members about their child's care on an ongoing basis, and in an appropriate and supportive manner.***

  Each family has the right to know all the information available about their child's needs and the service options available to meet those needs. This information should be shared in an open, honest, understandable, and sensitive manner.

- ***Implement appropriate, comprehensive services that provide emotional and financial support to meet the needs of families.***

  Each family is unique, with its own concerns, priorities, and hopes for the future. A family's needs may include respite, childcare, parent-to-parent support, transportation, and assistive technology. The family must have access to the supports and services necessary to meet those needs.

- ***Recognize the family's strengths, individuality, and methods of coping.***

  All families have individualized coping behaviors that they use on a daily basis. Services must recognize the appearance and value of these behaviors to each member of the family.

- ***Understand and incorporate the developmental needs of infants, toddlers, and families into everyday routines and activities.***

  Families of children with medical or developmental needs continue to have the need to "be a family."

Every family needs time to enjoy friends, recreation, community activities, and each other. Early intervention should encourage and support the child's participation within the family's daily activities.

❖ ***Encourage and facilitate parent-to-parent support.***

Parent-to-parent support provides families with an opportunity to share and benefit from each other's experiences and knowledge. Early interventionists can best support families by being aware of local advocacy and support organizations.

❖ ***Assure that services are flexible, accessible, and responsive to the family's needs.***

Families often report that inflexible services are a greater source of stress than the care of their children. Programs and policies must be responsive to the dynamic needs and goals of families.

❖ ***Honor the racial, ethnic, cultural, and socioeconomic diversity of families.***

Each family has its own beliefs, values, and preferences. Early interventionists can support families by being open to and accepting of diversity.

Family-centered care suggests that all services revolve around the family, as it is the family that will be the constant in the child's life. Early interventionists must become sensitive to the changing needs of the family as it copes with the ongoing needs of the child. Empathetic staff and flexible, coordinated family-centered services are crucial to the design of a collaborative early intervention service system.

Family-centered care requires that professionals should look closely at what they do now and envision what they can create. Look closely at their current practices and ask questions such as: Why are things done this way? Is this the only way possible? Is this the best way to do it? Is this the way it has always been done?

Activity 3.3

Using the following definitions, assess whether the examples listed below are family-centered, child-centered or system-centered.

Driving Forces:

S System-centered: the strengths and needs of the system drive the delivery of services.
C Child-centered: the strengths and needs of the child drive the delivery of services.
F Family-centered: the strengths and needs of the family drive the delivery of services.

__ A family must bring their child to the office for case management services.
__ A complete assessment of a child and family is done.
__ Occupational therapy sessions are arranged according to a family's schedule.
__ Child care is provided for siblings while the child with disabilities receives treatment.
__ The office hours of the dentist are Monday through Friday, 9:00 a.m. - 4:00 p.m.
__ A physical therapist sends the order for a seating device home with the child.
__ Transportation to the clinic is available from 9:00 a.m. - 5:00 p.m.
__ Parent support groups may use the facility's conference room in the evenings.
__ A local school board's planning committee consists of professionals, parents, and representatives from the community.
__ A child's medical records are available in three to five days after a release of information is received.
__ A speech therapist comes to the home twice a week for a one hour session with a child.
__ A care plan developed by a multidisciplinary team is given to the parent.
__ School is closed for a day so that parent/teacher conferences can be held.
__ Parents choose to send their child with diabetes to a church camp instead of a special camp for children with diabetes.
__ A hospital social worker arranges for all of the medical equipment ordered by a physician for a child.

Cultural Diversity

Just as the population of children who are considered to have special needs is not a homogeneous group, neither are the children's families. The early intervention professional serving infants and toddlers with disabilities will work with many families who vary by background and economic conditions, as well as by family structure. Each family will bring unique resources to the task of parenting their child with special needs, and each family will identify unique needs which must be addressed through early intervention.

In addition, early intervention programs are becoming much more sensitive to the cultural background of the enrolled families. This important variable contributes to the composition and operation of a family system. The families of infants and toddlers in the early intervention system represent all facets of American society and cultural backgrounds. The basic cultural components that must be considered as professionals work with families include language, communication style, religious beliefs, values, customs, food preferences and taboos; any of these factors may affect the family's perception of disabilities. Early interventionists must have the ability to understand the similarities and differences between their own cultural beliefs and values and those of the families they serve. The influence of cultural norms can be more significant than the influence of a specific intervention. Early interventionists must develop a sensitivity to the unique role these variables play in each family system.

Diversity should be valued. Diversity is not right or wrong. Diversity is a dimension of being that emphasizes the uniqueness of each and every one of us.

The first step in learning to be sensitive involves self-awareness. The awareness of individual assumptions and values can help to sensitize early interventionists to the belief system of the families receiving services. It is important to recognize that one viewpoint represents just one of the many ways to look at the world.

In addition to recognizing how values affect decisions and judgments, early interventionists must learn about differences in the cultures of the families served in early intervention. Knowledge and understanding of various cultures will enable the early intervention system to support families through the IFSP process. Cultural sensitivity means being aware and respectful of the unique cultural needs, values, and norms of a child and family. To demonstrate cultural sensitivity, early intervention service providers should:

- Recognize the diversity of other cultures.
- Develop individualized family service plans that are culturally acceptable.
- Establish clear communication (verbal and nonverbal) with all families (through bilingual and bicultural staff).
- Provide all information in the family's preferred language.
- Encourage respect for different values, beliefs, and practices.
- Cross language barriers and gain access to needed community services facilitating family empowerment.

Families should be at the center of the service delivery system.

Activity 3.4

Early intervention must be consistent with the family's beliefs and values. In order to provide effective services, we must learn more about the family's values and preferences. These preferences can include the family's:

- feelings toward seeking assistance from people outside the family.
- beliefs regarding food and mealtime rules.
- views on acceptable behavior for children.

List some of your family's beliefs, values, and priorities, and identify their origin.

The Family-Centered IFSP

The Individualized Family Service Plan (IFSP), mandated by Part H, is the keystone to the services provided to an infant or toddler with disabilities and his or her family. The plan must be written carefully to include the needs of the child, and the parents or other caregivers as related to the child's needs. With the focus on least restrictive, natural environments and family-centered care, there must be respect for the role of the family members. They are the people who know the child best, and who can delineate most accurately the child's strengths and needs.

Elements of an IFSP:

1. Information about the child's status, including present levels of physical development (vision, hearing, and health status), cognitive development, language and speech development, psychosocial development, and self-help skills, based on professionally acceptable objective criteria.

2. A statement, made with the concurrence of the family, of the family's concerns, priorities, and resources related to enhancing the developmental outcomes of the child.

3. A statement of the major outcomes expected to be achieved for the child and family and the criteria, procedures, and timelines used to determine: a) the degree to which progress toward achieving the outcomes is being made; and, b) whether modifications or revisions of the outcomes or services are necessary.

4. A statement of the early intervention services necessary to meet the unique needs of the child and family to achieve the stated outcomes including: a) the frequency, intensity, location, and method of delivering services; b) the payment arrangements, if any; and, c) the dates and duration of the services. (Frequency and intensity define the number of days or sessions that a service will be provided, the length of time the service is provided during each session, and whether the service is provided on an individual or group basis. Location means the place where the service is provided. Method means how the service is provided. Date means the specific day the service will start and the anticipated number of weeks or months of those services will be provided.)

5. A listing of other services that the child needs that are not required under the federal Early Intervention

Program for Infants and Toddlers with Disabilities and the steps that will be taken to secure services through private or public resources.

6. The name of the service coordinator who will be responsible for the implementation of the IFSP and coordination with other agencies and persons.

7. A listing of the steps to be taken to support the transition of the child, upon reaching age three, to public school preschools or preschool services under Part B of the IDEA or other services that may be available, as is appropriate for the child's needs.

Activity 3.5

In order to develop a family-centered IFSP, both early intervention service providers and families must collaborate in the process.

Describe what information and skills early intervention service providers and parents contribute to the development of the IFSP.

Professionals	Parents

Family Concerns, Priorities and Resources

In order to develop an effective IFSP for infants and toddlers with disabilities, early interventionists must become aware of each family's concerns, priorities, and resources. Furthermore, staff must be able to communicate with the family in order to establish collaborative goals for the child, and to design appropriate interventions that can be delivered in the context of the family. A family-centered approach to providing services to children and families is dependent on a relationship between early interventionists and families that is based on mutual trust and respect.

Knowledge of the family's concerns, priorities, and resources can be gained through periodic interactions with the family. Phone calls, home visits, and casual conversations are all opportunities to learn more about the family. These contacts can be used to identify:

- The names and roles of important people in the family's life.
- Questions the family would like answered.
- The child's history.
- The child's strengths and other relevant information such as favorite toys and games.
- Things the family finds to be difficult (e.g., locating sources of financial support, speaking with physicians about the child's care, filling out insurance forms).
- The family's typical routine and activities.

Early intervention service providers must be open and sensitive to what a family has to say. Families are more comfortable and willing to share their concerns when they sense trust and respect.

Certain guidelines can assist service providers and families when collaborating to identify a family's concerns, priorities, and resources. These include:

❖ ***The inclusion of family information in the IFSP is voluntary, not mandatory.***

Regulations do not require that family members participate in activities to identify their family's strengths and needs. Family information is included in the IFSP only with the family's consent.

- ***A need exists only if the family feels it exists.***

  To provide family-centered services, early interventionists must recognize the difference between helping families to identify their needs and leading families to agree with the needs they may see.

- ***Only family members can determine what aspects of their lives are relevant to the child's development.***

  The family has the right to decide what personal family information is relevant to its child's care. Early intervention service providers must respect the decisions a family makes. Only family information directly related to the family's expressed needs should be discussed. The family should never feel pressured to share sensitive, personal information.

- ***Families must have ongoing opportunities to identify their evolving needs and concerns.***

  Family responsibilities and concerns can change rapidly or slowly. Family members must be provided with ongoing opportunities to share their thoughts and concerns as they evolve.

The Role of the Family in the IFSP Process

The family plays a leading role in the development of an IFSP, which provides the infant or toddler the best possible early intervention program including:

Referral for Services

Anyone involved with the child (family members, professionals providing services to the family, childcare workers, etc.) can make a referral to the early intervention system, as long as the parents give permission. The first responsibility of the early intervention system is to determine the family members' concerns and priorities in regard to their child's development.

Evaluation/Assessment Planning

Evaluation determines if the infant or toddler is eligible for early intervention, while assessment of the child's strengths and needs is an ongoing process. As the child grows and develops, assessments will change; and, as the team, including the family, becomes more comfortable with each other, additional insights may arise. In the traditional assessment model, the family's needs and wants were not taken into account until after the service provider completed the assessment. In the IFSP, as outlined by Part H, the family's needs, wants, and goals are essential to the process, and must be identified before any assessment activities are planned.

Language associated with the assessment should reflect family values and preferences as much as possible. Some families dislike or misunderstand the term "evaluation," thinking of it as a test of some kind that may be passed or failed. Service providers on the team should pay attention to the language the family uses, and should feel free to ask the family what terms they prefer, and then use those terms throughout the tenure of their relationship.

The team needs to gather and exchange information in the following areas when planning an assessment:

- Child characteristics.
- Family preferences for involvement.
- Family priorities for both the child and family.
- Child records and other data from previous assessments or diagnoses.

Asking parents such questions as where they would like the assessment to take place, what activities and toys their child favors, what time of day their child naps, who should be present at the assessment, and what role the parents prefer during the assessment (e.g., helping with activities, sitting quietly beside the child, or carrying out some of the activities) will ensure that parents are involved to the extent that they desire, and that the child will be treated according to the family's wishes.

Assessment of a Child's Strengths and Needs

All assessment activities must be carried out with the signed informed consent of the parents. Formal observations or assessments should be used only when absolutely necessary, and then only with the consent of the parent or legal guardian. Unless the parents specifically choose not to be present at all meetings and assessment activities, they should to be included in all team activities.

It is important to assess the child's strengths, as well as his or her needs. Early intervention service providers are often focused on what the child *cannot* do, and they may need help in recognizing what he or she *can* do, and what the family has learned from living with the child. Insight about a child's strengths can be gained by asking parents for information such as: 1) a description of the child, or a typical day with the child; 2) what the child likes to do; and, 3) recent changes or progress the child has experienced.

The assessment must focus on the child's current level of functioning, including physical, emotional, social, learning style, language development, and personal independence abilities. There are many standardized tests, checklists, and observational measures available to gather this information. The assessment needs to be tailored to the individual child, and to the wishes of the family.

Assessment results must always be shared openly and honestly with all members of the team. Parents and service providers discuss the findings so that everyone has a complete understanding of the results and interpretations.

Identification of the Family's Concerns, Priorities, and Resources

The family's self-identified concerns, priorities, and resources are shared with the whole team through informal discussions, home visits, phone calls, and any other methods used by the family.

Development of Outcomes

Outcomes are the changes the family want to see happen for the child and the entire family system. Outcomes can be related to any area of a child's development or family life. For example, a family's outcomes may include the development of specific skills related to eating, playing or dressing, or the ability of the parents to go out occasionally while their child is in the care of someone they trust. Outcomes, like the other sections of the IFSP, are written without jargon, and focus on useful skills.

Implementation and Service Delivery

The implementation of the IFSP delivers the actual services and supports to meet the needs of the child and family. As with the assessment plan, service delivery must be family-centered, responsive to emerging needs, supportive of family strengths, and above all, flexible.

The family will decide how involved they want to be in the actual provision of services. Some families may want to be very involved, while others may choose to be minimally involved. The degree of involvement may change as the family's needs change, and the team must be sure that the family is supported in its decision, whatever that decision may be.

Activity 3.6

Describe how families are currently involved within your agency or program in each of these six components of the IFSP process.

Referral for Services ________________________________

____

Assessment Planning ________________________________

____

Assessment of a Child's Strengths and Needs ________________________________

____

Identification of the Family's Priorities, Resources, and Concerns ________________________________

____

Development of Outcomes ________________________________

____

Implementation and Delivery of Services ________________________________

____

Now think about Polly and her parents. What role is Polly' family playing in the IFSP process?

Is Polly's service delivery child-, family- or system-centered?

What things can be done to make Polly's service delivery less stressful on her family?

Notes

TEAM COLLABORATIONS

While infants and toddlers with disabilities may require the combined expertise of numerous professionals providing specialized services, the coordination of both people and services is frequently overwhelming. For example, personnel having medical expertise, therapeutic expertise, educational/developmental expertise, and social service expertise traditionally have been involved in the provision of services to infants and toddlers with disabilities and their families. Each of these service providers may represent a different professional discipline and a different philosophical model of service delivery. In fact, each discipline has it own training sequence (some require undergraduate, while others require graduate degrees), licensing or certification requirements (most of which do not require age specialization for young children), and treatment modality (e.g., occupational therapists may focus on sensori-integration techniques). In addition, many disciplines have their own professional organization that encompasses the treatment needs of persons across the entire life span, instead of organizations focused on a single age group. Nonetheless, as services for young children with disabilities continue to grow, so too does the need for professionals. Table 4-1 contains a list of the professional disciplines most typically involved in services for young children with disabilities and their families.

In order to improve the efficiency of the individuals providing early intervention, it has been suggested that services be delivered through a team approach. A group of individuals does not become a team spontaneously. A group becomes a team when its members work together to accomplish shared goals. Team members pool their knowledge to solve common problems and implement mutually agreed upon solutions.

Activity 4.1

Think about your own experiences with groups of people on teams, committees, or boards. What helped the group function well?

Table 4-1: Professional Disciplines in Early Intervention

- Audiologist
- Early childhood special educator
- Neurologist
- Nutritionist
- Nurse
- Occupational therapist
- Ophthalmologist
- Optometrist
- Physician
- Psychologist
- Physical therapist
- Social worker
- Speech-language pathologist
- Vision specialist

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Effective Teams

A truly effective team exists when members share responsibility for accomplishing common goals. An effective team will:

- ***Have goals which are clearly understood and communicated to all team members.***

  A collaborative philosophy or mission provides the team's overall reason for existence and a focus for its actions. A written statement of the collaborative philosophy will clearly delineate the team's direction. A team will function effectively to the extent that its philosophy is clear and accepted by all of its members.

- ***Recognize the contributions of all team members.***

  Effective teams are supportive, creating an environment where every team member feels comfortable and free to express his or her concerns, thoughts, and reactions. There is no single person who is more important than any other on an effective IFSP team.

- ***Communicate effectively among members.***

  Effective communication occurs when the listener clearly understands the speaker's intended message. Team members communicate effectively when they listen to what others are saying and respond using language that is understandable and jargon free. While jargon makes it easy for service providers within a particular discipline to communicate with each other, it makes it difficult for a team composed of multiple disciplines and family members to communicate effectively. Miscommunications can occur when individual team members assign different meanings to the same terms.

The highest level of achievement is attained when the whole team is committed to the task, and full use is made of each member's talents.

Activity 4.2

Use the chart below to determine if a group you are in is functioning as a team.

GROUPS	TEAMS
☐ Members think they are grouped together for administrative purposes only. Individuals work independently; sometimes at cross purposes with others.	☐ Members recognize their interdependence and understand both personal and team goals are best accomplished with mutual support. Time is not wasted struggling over "turf" or attempting personal gain at the expense of others.
☐ Members tend to focus on themselves because they are not sufficiently involved in planning the unit's objectives. They approach their job simply as a hired hand.	☐ Members feel a sense of ownership for their jobs and unit because they are committed to goals they helped establish.
☐ Members are told what to do rather than being asked what the best approach would be. Suggestions are not encouraged.	☐ Members contribute to the organization's success by applying their unique talent and knowledge to team objectives.
☐ Members distrust the motives of colleagues because they do not understand the role of other members. Expressions of opinion or disagreement are considered divisive and non-supportive.	☐ Members work in a climate of trust and are encouraged to openly express ideas, opinions, disagreements and feelings. Questions are welcomed.
☐ Members are so cautious about what they say that real understanding is not possible. Game playing may occur and communications traps be set to catch the unwary.	☐ Members practice open and honest communication. They make an effort to understand each other's point of view.
☐ Members may receive good training but are limited in applying it to the job by the supervisor or other group members.	☐ Members are encouraged to develop skills and apply what they learn on the job. They receive the support of the team.
☐ Members find themselves in conflict situations which they do not know how to resolve. Their supervisor may put off intervention until serious damage is done.	☐ Members recognize conflict is a normal aspect of human interaction but they view such situations as an opportunity for new ideas and creativity. They work to resolve conflict quickly and constructively.
☐ Members may or may not participate in decisions affecting the team. Conformity often appears more important than positive results.	☐ Members participate in decisions affecting the team but understand their leader must make a final ruling when the team cannot decide, or an emergency exists. Positive results, not conformity are the goal.

From: Maddux, R.E. (1988). Team building: An exercise in leadership. *Crisp Publications*

The types of teams that typically function within service delivery models for young children with disabilities have been identified as multidisciplinary, interdisciplinary, and transdisciplinary. While the transdisciplinary team model has been identified as the ideal for early intervention, other team models have also been identified and used for service delivery. A number of components that differentiate between types of teams have been identified, including the role of the family on the team, the mode of communication among team members, the role-clarification process, and the mode of intervention. Table 4-2 provides an overview of the three team models.

Table 4-2: Team Models

	MULTIDISCIPLINARY	INTERDISCIPLINARY	TRANSDISCIPLINARY
Guiding Philosophy	Team members recognize the importance of contributions from other disciplines.	Team members are willing and able to develop, share, and be responsible for providing services that are a part of the total service plan.	Team members make a commitment to teach, learn, and work together across discipline boundaries to implement a unified service plan.
Family Participation	Family meets with individual team members.	Family meets with team or team representative(s).	Family is full, active, and participating member of the team.
Assessment	Separate assessments by team members.	Separate assessments by team members; may use common tool.	Team members and family plan and conduct a comprehensive assessment together.
Goal Setting	Team members develop separate plans for their discipline.	Team members share their separate plans with one another.	Team members and family develop a service plan based upon family concerns, priorities, and resources.
Treatment	Team members implement the part of the service plan related to their discipline.	Team members implement their section of the plan and incorporate other sections where possible.	A primary service provider is selected to implement the plan with the family.
Lines of Communication	Informal lines.	Periodic case-specific team meetings.	Regular team meeting where continuous transfer of information, knowledge, and skills are shared among team members.

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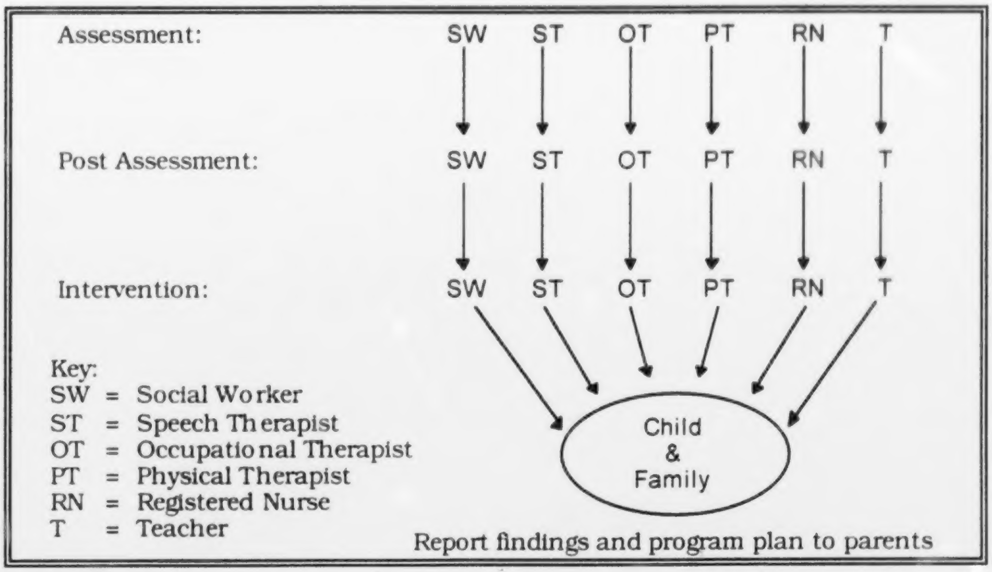
Multidisciplinary Teams

On a multidisciplinary team, the professionals represent their own discipline and provide isolated assessment and intervention services. This includes individual report writing, individual goal setting, and discipline-specific direct intervention with the child and/or family. The parent is invited to share information with the professionals, and the professionals in turn share the information from assessment, intervention, and follow-up with the family through an "informing" conference. There is minimal integration across the disciplines, and the family members are passive recipients of information about their child. This model makes it very difficult to develop coordinated integration across the disciplines, and the family members are passive recipients of information about comprehensive programs for families and their children. Figure 4-1 contains an overview of this type of team.

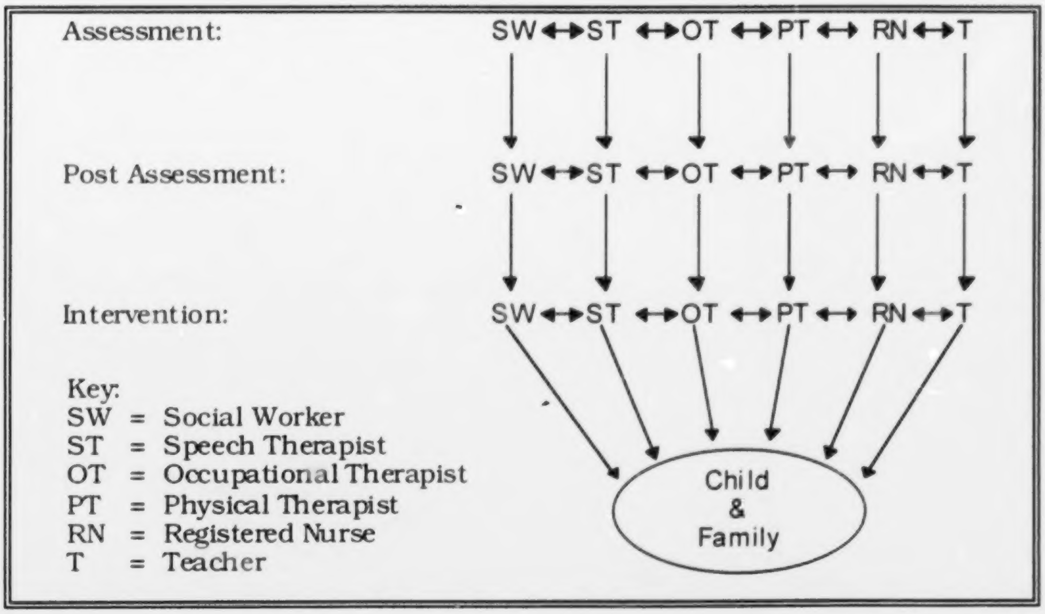
Figure 4-1: Flow of Information on a Multidisciplinary Team


Assessment:
SW ST OT PT RN T
Post Assessment:
SW ST OT PT RN T
Intervention:
SW ST OT PT RN T
Key:
SW = Social Worker
ST = Speech Therapist
OT = Occupational Therapist
PT = Physical Therapist
RN = Registered Nurse
T = Teacher
Child & Family
Report findings and program plan to parents

Interdisciplinary Teams

On an interdisciplinary team, each of the professionals carries out specific disciplinary assessments and interventions. The degree of communication between the professionals and the family represents a formal commitment to the sharing of information throughout the process of assessment, planning, and intervention. However, the assessments and interventions are usually implemented by individuals representing separate disciplines. In many cases, the parents are active members of the team, but their input is generally considered secondary in importance to the material collected by the professionals. Figure 4-2 contains an overview of this type of team.

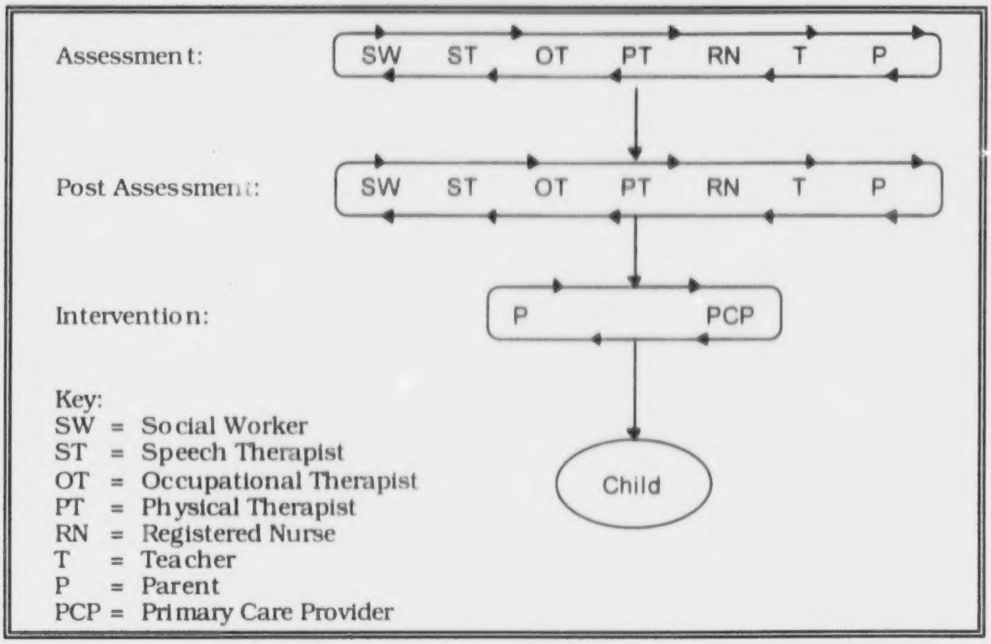
Figure 4-2: Flow of Information on an Interdisciplinary Team


Assessment:
SW↔ST ↔OT ↔PT↔ RN↔T
Post Assessment:
SW↔ST ↔OT ↔PT↔ RN↔T
Intervention:
SW↔ST ↔OT ↔PT↔ RN↔T
Key:
SW = Social Worker
ST = Speech Therapist
OT = Occupational Therapist
PT = Physical Therapist
RN = Registered Nurse
T = Teacher
Child & Family

Transdisciplinary Teams

The transdisciplinary approach originally was conceived as a framework for professionals to share important information and skills with primary caregivers. This approach integrates a child's developmental needs across the major developmental domains. The transdisciplinary approach involves a greater degree of collaboration than other service models and, for this reason, may be difficult to implement. It has, however, been identified as ideal for the design and delivery of services for infants and toddlers with disabilities receiving early childhood intervention. Figure 4-3 contains an overview of this type of team.

Figure 4-3: Flow of Information on a Transdisciplinary Team


Assessment:
SW ST OT PT RN T P
Post Assessment:
SW ST OT PT RN T P
Intervention:
P PCP
Child
Key:
SW = Social Worker
ST = Speech Therapist
OT = Occupational Therapist
PT = Physical Therapist
RN = Registered Nurse
T = Teacher
P = Parent
PCP = Primary Care Provider

A transdisciplinary approach requires the team members to share roles and systematically cross discipline boundaries. The primary purpose of the approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. The communication style in this type of team involves continuous give and take between all members (especially the parents) on a regular, planned basis. The team members teach, learn, and work together to accomplish a common set of intervention goals for a child. Role differentiation between disciplines is defined by the needs of the situation, as opposed to discipline-specific characteristics. Assessment, intervention, and evaluation are carried out jointly by designated members of the team. This usually results in a decrease in the numbers of service providers that interact with the child on a daily basis. Other characteristics of the transdisciplinary approach are joint team effort, joint staff development to ensure continuous skill development among members, and role release.

Role release refers to a sharing and exchange of certain roles and responsibilities among team members. It specifically involves sharing of some functions traditionally associated with a specific discipline. For example, the physical therapist may provide training and support to the early childhood teacher to enable her to position a child with physical disabilities. Likewise, the nurse may provide training to all team members to monitor a child's seizure activities. Effective implementation of the role release process requires adequate sharing of information and training. Team members must have a solid foundation in their own discipline combined with a knowledge base that recognizes the roles and competencies of the other disciplines represented on the team.

All team members have unique skills and information they can share with others, therefore role release must occur across all team members.

Activity 4.3

Write your job title, discipline and/or role on a team on a piece of paper. If you are in a group, share it with others. Then throw the piece of paper away. How do you feel? Would it help team development if we could "release" our role?

There are four assumptions that govern the transdisciplinary team model:

1. Natural environments are the best place to assess and develop children's abilities.
2. Children should be taught clusters of skills needed for everyday living. These skills are best taught through natural routines and activities.
3. Discipline-specific goals and objectives should be implemented throughout the day and in all the settings in which the child functions.
4. Skills must be taught and reinforced in the settings in which they naturally occur.

Activity 4.4

List some advantages of the transdisciplinary approach in early intervention that you recognize.

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In the transdisciplinary approach, the child's program is primarily implemented by a single person or a few persons with ongoing assistance provided by team members from the various disciplines. This strategy facilitates the delivery of appropriate interventions across developmental domains throughout the child's day, as opposed to having a specific speech therapy session, fine motor occupational therapy session, etc. This does not mean that different interventionists stop providing direct services to children. In reality, in order for early intervention to be effective, all service providers need to maintain direct contact with the child with a disability. The provision of this team model should never be used as a strategy to justify the reduction of staff.

There are a number of factors a transdisciplinary team must consider as it prepares to assign roles and responsibilities, including:

- ***The needs of the child and family.***

  When assigning roles and responsibilities for service delivery, the intervention team's first consideration should be the family's needs and concerns related to the development of the child. The competencies of the individuals selected to implement interventions should fit the child's needs and abilities. When assigning roles, the team should consider carefully the competencies and interests of individual service providers rather than the specific skills associated with a particular discipline.

  For example, a speech pathologist is trained to work effectively with children who have speech and language impairments. However, if the child has other needs that impact his or her speech development, the speech pathologist must also be able to attend to those needs; and, at times, those needs might overlap into a different developmental area, such as motor or cognition. The most important criteria for selecting service providers is that they have an open and trusting relationship with the family, a supportive and integrated team from which to receive guidance, and an interest in providing developmental support and intervention to the child.

- ***The skills and knowledge of individual team members.***

  Service providers should be selected who have the skills needed to address multiple needs. For example, a special educator may be selected as the primary interventionist because he or she can address a particular child's cognitive, social, and language needs. The speech pathologist may serve as a consultant, helping the special educator embed the child's communication goals into daily activities.

- ***The availability of service providers.***

  One of the assumptions of the transdisciplinary model is that children should be taught skills needed for everyday living. These skills are best taught through natural routines and activities. Some service providers, who have the competencies to address a child's needs, may not have the access to the child's natural environments. For example, a physician may be the most familiar and influential service provider for a family with a child who has medical needs. However, physicians typically work in very specialized and isolated settings. Therefore, an intervention team might select a nurse as the primary person responsible for implementing the intervention program. The physician could consult with the team on how to meet the child's healthcare needs in the home and other community settings. Additionally, the physician may continue to provide direct services by monitoring the child's health and dispensing medical treatment.

Although collaborative transdisciplinary service delivery teams appear simple in concept, implementation of this strategy can be difficult because of the differences between it and the more familiar structured, discipline specific team structures. Barriers to the effective use of this service delivery strategy have been identified as philosophical, professional, interpersonal, and administrative. In particular, the time commitment required to implement a collaborative team model effectively across the necessary disciplines and individuals may be difficult for some early childhood programs. Additionally, many early childhood intervention staff may not have expertise or experience in a collaborative, transdisciplinary team approach, thus diminishing the feasibility of such a strategy.

Team Process

Whether developing an assessment protocol or an IFSP, the common denominator to team effectiveness is the use of a functional process. Unfortunately, many service providers lack the skills necessary to maintain an effective team process. These skills include the ability to overcome barriers, the motivation to accomplish the team's mission and goals, and the perseverance to maintain positive interactions. Five factors that affect the development and maintenance of a team have been identified. It is important for members to be aware of these factors and to understand how they influence team development and maintenance.

Team Composition and Representation

Many factors influence the performance and development of the team. Program or agency affiliation of the members exerts a strong influence on the team process. For example, the resources available to a team depend on the participating programs and/or agencies. These resources can include money, administrative support, and time. Teams with fewer resources need to be more creative in identifying and implementing solutions.

Additionally, a group's size and membership composition will affect collaborative outcomes. Different teams have variations in structure, and all agencies and/or disciplines will not necessarily be represented on every team. The number of personnel and the variety of roles each play may vary dramatically, depending on the needs of the child and his or her family and on the purpose of the team.

Team Goals

Teams must devote time to identifying their goals and objectives. A truly effective team is made up of members who share responsibility for accomplishing common goals. An effective team:

- ***Adopts goals that are clearly understood, and communicated to all team members.***

  A collaborative philosophy or mission is the team's overall reason for existence and it provides the team with a focus for its actions. A written statement of the collaborative philosophy clearly delineates the team's direction. A team functions effectively to the extent that its philosophy is clear and agreed upon by all participants.

Activity 4.5

List the members of the early intervention team on which you currently serve.

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- ***Shares ownership of the goals and participates in setting them.***

  All team members (including the family) need to feel that their input is valued. This helps to ensure that the goals are clearly understood by everyone on the team.

- ***Delineates goals that are operationally defined and measurable.***

  Goals must be written in such a way that everyone has a clear understanding of what is expected, and how success will be determined and measured.

- ***Conveys individual or personal objectives with one another.***

  Since teams are comprised of individuals, it is important to respect the human elements of any team.

Activity 4.6

List and describe the goals of the early intervention team to which you belong.

Roles Within the Team

The members of a team are unique individuals who possess different skills, knowledge, and personalities. To be effective, each team member must be assigned a role and clearly understand the identified responsibilities. Ambiguity is a major cause of conflict, therefore team members must continually clarify their current roles, including that of the leader.

In addition to the typical professional roles, responsibilities, and contributions of team members, members will assume other roles with regard to team development, maintenance, and problem solving. These roles, or functions as they are sometimes called, must occur within the group in order for the team to progress effectively.

To facilitate an effective team process, every team member has a responsibility to:

- Prepare family members for their role on the team and encourage their active participation.
- Share their expertise with other team members.
- Offer recommendations for addressing a service or a child's need from his or her own perspective or area of expertise.
- Listen actively and use good communication skills. Be clear and concise when reporting information, and avoid the use of jargon that other team members may not understand.
- Recognize the contributions of other team members, and encourage the sharing of information.

Team Work Style

The team's work style affects the team's development and overall effectiveness. Effective team decisions result from the use of a systematic problem solving process. If that process occurs haphazardly, the team is less likely to make appropriate decisions. The probability of an effective outcome is increased when a formalized, systematic process of problem solving is applied. Systematic problem solving ensures that members are satisfied with, and committed to, team decisions.

Activity 4.7

Describe the problem-solving process your team currently uses.

The literature offers a variety of problem-solving models. One model, PROJECT BRIDGE, recommends a five-step process which serves two functions. In the first function, each step serves as a check point for problem solving. Concurrently, in its second capacity, the process acts as an evaluation tool to compare team ideas and practices to the model of best practices to exemplary services in the field of early childhood education. The steps include:

- ***Problem formulation and information gathering.***

  Describe the problem in clear and observable terms. Identify resources. Throughout, focus on facts, rather than opinions.

- ***Generating proposals for solution.***

  Generate as many alternatives as possible. Withhold judgment and build positively on all suggestions.

- ***Selecting alternatives and testing solutions.***

  Explore the available resources, and evaluate the alternatives in order to attain the best solution. Decide whether or not the solution makes good use of the resources, is cost effective, and fits the needs and goals of the child and family.

- ***Action planning and implementation.***

  Assign specific responsibilities to individuals, determine timelines, and develop procedures to monitor the plan. Communicate the finished document to all relevant personnel.

- ***Monitoring and evaluation.***

  Develop a scheme to judge the success of any decisions. Include in the scheme a unit of evaluation, and how often to evaluate. Modify the plan as needed.

Planned meetings are the hub of the team process. The team must work face-to-face in order to function, and the planned meeting serves as a vehicle for facilitating the completion of the team's tasks and the achievement of its goals. A well-functioning team meets at regularly scheduled times and all team members attend. An effective team meeting begins with a purpose or goal identified in a written agenda, and includes both general team and specific individual charges and problem-solving tasks. Distribute the agenda in advance of the meeting so that team members can prepare for discussion of the issues. Previously established meeting roles (i.e., facilitator, recorder, timekeeper, etc.), and rules (including policies of confidentiality, timeframes for topics, and orders for procedure, etc.) will expedite meeting activity. Keep a written record of the attendees and the meeting business to document recommended actions, to provide follow-up, and to track progress. A well-planned meeting ensures that communication between the team members evolves into a habit.

Activity 4.8

Use the five-step problem-solving process of PROJECT BRIDGE to solve some of the concerns of Polly's parents.

Problem formulation
and information gathering

Generating proposals
for solution

Selecting alternatives
and testing solutions

Action planning
and implementation

Monitoring
and evaluation

Team Leadership

A team is comprised of individuals who are products of their past experiences and, consequently, bring different attitudes, values, and beliefs with them to the team. Individuals also bring expectations about the team: how it should function and what it should accomplish, for example. The personalities of the team members may ultimately determine the team's effectiveness.

Team leaders must adapt their style to meet the diverse needs and styles of the individuals who make up the group. The team leader should foster a climate in which all members feel free to contribute their ideas. In this atmosphere, the members can express differing viewpoints and proposed solutions.

Teams may have formal leaders who are assigned, appointed, or elected by group endorsement. Informal leaders may emerge because of their influence. The team may accept or propel a person into an informal leadership role for a number of reasons: his or her knowledge, skill, personal qualities, or because of the ineffectiveness of the formal leadership. Often, both types of leaders operate simultaneously. This can precipitate problems if the team members ignore the distinctions between informal and formal roles or misappropriate the functions of each. A team leader has a number of roles or functions with regard to a team's development. The main function of the leader is to focus the team on its collective responsibility, which is to ensure that collaborative early intervention services are delivered effectively.

As previously stated, the leadership role within an early intervention service delivery team should be assumed by the service coordinator. The service coordinator has the responsibility for ensuring that the team members put aside their individual agendas in order to focus on the needs of the family and child. The service coordinator will have to facilitate the communication process so that team members develop mutual goals and strategies with the family. Communication is one skill which all team members will have to emphasize to develop an effective and functional team process.

Activity 4.9

Who should be Polly's service coordinator, and how could the team organize her service delivery plan to create a more transdisciplinary model?

Notes

SKILLS FOR COLLABORATIONS

Collaborative service delivery models yield a broad range of benefits. The most important benefit is identified as the improvement in service delivery to children with disabilities and their families. Collaborative efforts enable parents and service providers to efficiently locate and manage the services required by the family. Yet, service providers, as well as the community, gain from the collaborative model with a more efficient and effective use of available resources--manpower, material and money--across agencies.

The mere recognition of the benefits has not resulted in effective collaborations. Today, collaborative early intervention service systems remain an elusive goal for many states. Fragmented and isolated services continue to occur by default, rather than by choice, because professionals have not had the opportunity to learn and practice alternative ways of working together. Communication across disciplines is one such skill that is key to the collaborative process.

The Communication Process

On an average, individuals spend 70% of their waking hours communicating with others. Communication is fundamental to all relationships, and the substantial component of human relationships. Easily taken for granted, good communication between individuals is a complete and intricate process which requires constant attention and consistent application.

Communication is the process of exchanging information between two or more people. It is not only the exchange of information that is important, but the process by which the information is exchanged. The communication process is impacted by circumstance, situation, and context. It is also affected by environment: the physical, social, and emotional conditions. The more complex the task, information, or goals, the more important communication processes are to successful outcomes.

During the process of communication, information can be shared in a *unilateral*, *directive*, or *transactional* manner.

- *Unilateral* communication is one-way, and involves no face-to-face contact. Films, videos, letters, books, and taped lectures are examples of unilateral communication.

- *Directive* communication is face-to-face, but again is only a one-way sharing of information. Examples include lecturing, directing, and explaining.

- *Transactional* communication is face-to-face and two-way. All participants in the interaction are involved in the exchange; all send and receive messages, and all speak and listen. The purpose of transactional communication is to arrive at shared meanings.

Components of Communication

In order for good communication to occur, we need a sender, a message, and a receiver. The sender must be able to formulate the information to be transmitted, and to evaluate the importance of that information to the situation at hand. He or she then converts the message into verbal and nonverbal messages (nonverbal messages are usually unconscious). Finally, he or she sends the message in a way that is appropriate for the receiver in terms of form of expression and amount of information.

The receiver must be able to listen actively, select what is important in the verbal message, and recognize the messages being conveyed nonverbally. The receiver's state of mind and level of comfort will impact one's ability to attend to and receive information. The receiver then interprets the message, either understanding or misunderstanding it. Accurate interpretation is based on self-awareness, a desire to understand, and a willingness to ask for clarification. After asking clarifying questions and gaining all the important information, the receiver can form an opinion and a response. It is difficult not to jump to opinions and conclusions before all the information is clearly understood.

The next step for the receiver is to respond to the message, and to let the speaker know through verbal and nonverbal feedback what was heard and how it was understood and evaluated. In this step, the receiver becomes the sender.

In any spoken message, approximately 7% of the meaning is carried by the words used. Another 38% of the meaning is transmitted through the vocal behavior of the speaker, including the voice quality, intonation, rate of speech, etc. The remaining 55% of meaning is conveyed by nonverbal behaviors. For example, if someone says, "I'm really glad to be here," and the person is standing with eyes downcast, shoulders stooped, brow wrinkled, and arms crossed, we would have a hard time believing that the sender was really glad to be there!

> ***Communication occurs when the right person says the right thing, to the right people, at the right place, at the right time, and in the right way to be heard and understood, and to produce the desired response.***
>
> ***Nido R. Qubein***

Activity 5.1

Think of two or three statements or remarks heard in your professional setting that bother you (e.g., "That family will never be able to get their act together!"). What is it that disturbs you about this statement? What does the statement imply to you? Why does that implication bother you? Imagine the possible frames of reference someone who makes such a statement may have. Try to generate four or five different frames.

Communication Strategies

Good communication builds trust because the listener interprets the message exactly as the speaker intended. This means the speaker must be skilled at both verbal and nonverbal message delivery.

Verbal Communication

Words must be clear and understandable. To accomplish this, the early interventionist should:

- ***Clarify words that may have more than one meaning.***

  For example, saying a child's performance is "average", could mean all children the same age as the child are expected to do as well, that 50% of the children his age would be able to do it, or that it is acceptable for the child's age.

- ***Avoid using professional jargon.***

  Parents do need to learn the terminology relating to their own child's disability, but this should be introduced and explained over time. Whenever possible, common words should be used and all abbreviations should be explained.

  For example: When communicating with a parent, an inappropriate statement would be, "At the IFSP meeting, you will get the results of the OT's assessment and we will discuss options for an oral motor stimulation."

A clearer, appropriate statement could be, "We will be meeting to discuss Melissa's feeding needs. Jane Brown, the occupational therapist, will explain what she learned by watching Melissa. We will then be able to discuss how to help Melissa strengthen and coordinate her sucking and swallowing so she can learn to drink from a bottle."

Nonverbal Communication

A lot of communication can be transmitted nonverbally, sometimes unintentionally. Early interventionists should:

- ***Monitor voice tone so it corresponds with the verbal message.***

  Supportive and helpful messages will not be heard if an angry tone of voice is used.

- ***Speak clearly.***

  Be careful not to mumble or use a voice that is too soft or booming.

- ***Pace speech.***

  Be careful not to talk too quickly or too slowly.

- ***Monitor facial expressions to minimize misinterpretations.***

  If a person's facial expression appears tired and bored, it may be interpreted to mean indifference or intolerance. If someone's expression is always smiling and happy even when discussing difficult problems, it could be interpreted as superficial, insincere, and unempathetic.

- ***Use appropriate eye contact.***

  Eye contact indicates interest and attention.

- ***Use appropriate gestures.***

  Nonverbal communication can deliver the message. Be aware of any distracting or repetitive gestures that you use.

- ***Monitor posture.***

  Posture can indicate interest. Constant changes of position suggest restlessness and boredom.

Listening Skills

In order to complete a communication interchange that is helpful and productive, early interventionists should also be able to demonstrate effective listening skills with parents. To communicate interest in, and acknowledgment of, what is being said, early interventionists should:

- ***Use open-ended questions to clarify information.***

  Close-ended questions (answered by one word or yes/no) should be avoided except to clarify a point. For example:

  Open-ended:
  How do you think Billy's development will be affected by his cerebral palsy?

  Close-ended:
  Do you understand how Billy's development will be affected by his cerebral palsy?

- ***Use subtle encouragers.***

  Head nods, "umhmms," smiles or other facial expressions, and comments such as "Tell me more" can be used to indicate interest and a desire to hear more.

- ***Listen, and do not talk too much.***

  Interruptions, unsolicited advice, and comments that do not relate to the topic indicate a lack of interest in what is being said and may be interpreted as being critical. This may discourage parents from saying more.

- ***Clarify any words, time frames, or expressions that may be misinterpreted.***

  For example, if a father says his son has been hyperactive since he was a baby, ask him to give you some examples of the son's hyperactivity. Also, clarify the child's age. In their family, does "baby" mean infancy, toddler period, or an age older than age two?

- ***Repeat back what was heard.***

  By simply repeating the information given by the parent, acknowledgment and acceptance is communicated.

- ***Reflect the parents' feelings.***

  Reflecting feelings is more difficult than repeating facts, but it is a critical part of effective listening.

- ***Paraphrase and summarize comments.***

  It is important to periodically review what has been said. This step assures the parents that the content, sequence, and facts have been heard correctly. It is particularly important to do this at the end of the meeting or conversation.

Active listening is a skill that can be developed to improve the listener's ability to hear and interpret the message accurately. The active listener provides feedback to the speaker about what the listener is understanding, thereby allowing the speaker to agree that what was understood is what was intended, or, if not, to clarify the speaker's intention. Active listening communicates respect, understanding, empathy, and acceptance.

People can often solve their own problems if given the chance.

Activity 5.2

For this activity, choose a partner. Decide who will be the message sender and who will be the message receiver. The message sender should paraphrase the situation facing Polly's family. The receiver should take notes on the verbal and nonverbal messages that facilitate and inhibit the communication process.

Facilitators ______________________________

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Inhibitors ______________________________

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Barriers to Communication

Communication always contains an element of risk, thereby inhibiting the exchange of information. Often a dilemma exists between an individual's need to communicate and be heard and fear of rejection, failure, or ridicule. People may deal with their fears by keeping silent, censoring what they say, pretending to agree, or phrasing their thoughts in vague or ambiguous ways. All of these behaviors interfere with the communication process. On teams, the amount of risk is compounded by the number of people present. Sometimes people assume there is no need to talk ("If it isn't broken, don't fix it"), or that there is no need to listen ("She's talking to the PT; it really doesn't concern me"), or they assume there is no need to respond.

One-way communication, as in lecturing or telling someone how something should be, can also inhibit communication by sending mixed messages.

Vocal expressions that block effective communication include speaking in a loud and fast voice, and using high or aggressive tones, and using infrequent pauses.

On the receiver's end, a noisy or distracting environment, daydreams, simultaneous thoughts about a response to the speaker's message, and emotional distraction are the four elements most likely to prevent the listener from accurately receiving the message. People need to take responsibility for their communication by minimizing distractions when possible, or postponing communication until a later time when the distractions will not be a factor. Listeners need to pull themselves back from the tendency to daydream, and make an effort to concentrate on the speaker. Sometimes stopping to take a break, taking notes, asking questions, or simply shifting one's body position can help. The listener needs to let the speaker complete the message before considering a response.

Often it is difficult for us to listen for a number of reasons. We are not taught to listen, but rather to express our own thoughts and opinions. Assertive communication is rewarded in many arenas, and sometimes people are so busy talking that they are unable to listen. Many times we prejudge the speaker, and our preconceived notions make it difficult for us to take the person seriously or to really listen to what he or she has to say. It is important for us to learn to be aware and respectful of diverse interests, opinions, and values, including those that may be very different from our own.

Activity 5.3

Choose someone to tell a story to about "my first day at my current job" or "why I became an early interventionist." Then ask the listener to repeat back to you the story as they heard it. Both of you then fill out the following checklist on your communication skills: evaluating them as you were telling the story (presenting) and hearing it back (receiving).

Effective Communication Self Review

PRESENTING INFORMATION	YES	NO
Verbal Messages: While presenting information to the listener I clarified the meaning of any word that could have more than one meaning.		
I avoided professional jargon.		
Nonverbal Messages: I tried to be aware of my tone of voice and kept it consistent with the verbal message.		
I spoke clearly at all times.		
I paced my speech at all times.		
Body language: I tried to keep my facial expression consistent with the verbal message.		
I used eye contact when appropriate.		
I remained aware of my use of gestures, posture, and position at all times.		

RECEIVING INFORMATION		
To communicate interest: I used open-ended questions instead of close-ended whenever possible.		
I did little talking and more listening.		
To communicate understanding: I asked for clarification on points that were unclear.		
I reflected facts and feelings back to the speaker.		
I paraphrased and summarized the speaker's comments.		

Trust Building

Communication is facilitated when the people communicating: 1) trust one another; 2) feel confident that they share the same goals; 3) work together in the service of families; and, 4) deal openly with any disputes that may arise. When this occurs, people feel comfortable asking questions, clarifying information, providing honest feedback, challenging assumptions, admitting that they do not have all the answers, and deciding together on the best course of action. When people are comfortable with each other, there is tacit permission to disagree, ask questions, and not have all the answers. Each member of the group feels respected, listened to, and valued.

The development of trust is a slow process. Someone takes a risk by disclosing some small thing; the team is supportive, the climate is comfortable, and people learn that it is okay to take risks. Gradually, the risks become larger, as people become more secure in their belief that they will be supported and respected by the other team members.

This kind of open communication fosters effective problem solving, demonstrates empathy and acceptance, minimizes misunderstandings, and helps each team member gain insight into the values, experiences, and attitudes of others.

Negotiation and Conflict Resolution Skills

During the collaborative process, communication may result in conflict. Conflict is any situation in which one person or group perceives that another person or group is interfering with his or her goal attainment. Conflict is a natural part of human interaction and should not be feared, but rather, managed. It is possible for disputing parties to have all of their needs met in a win/win resolution.

People tend to approach conflict in a variety of ways. There are five common styles of conflict management, each of which presents benefits and drawbacks. The style of conflict management used in a situation often depends on the content and context of the issue.

One style of conflict management is the ***competitive*** style. This style is characteristic of people who tend to overpower others with whom they have a conflict. Their goal is to win, regardless of possible negative consequences. This may be an appropriate style to utilize when there are ethical concerns or when one is certain of being right. However, some pitfalls of the competitive style are that others may stop engaging in meaningful interactions and collaborative relations can be seriously inhibited or destroyed.

Avoidance, a second style of conflict management, occurs when people try to avoid conflict by ignoring discrepancies between their own goals and those of others. When conflict is emotionally laden and people need time to regain their composure, avoidance may be a very appropriate and sensitive method for handling conflict. However, this approach can give a false sense that all is well. By not addressing the issue directly, conflict can continue to plague the group and may escalate as the result of inaction.

People who put aside their own needs in order to ensure that others' needs are met are engaging in an ***accommodating*** style of conflict management. Accommodating is appropriate when the conflict is relatively unimportant or when you are unable to alter an adversarial situation. The negative ramifications, however, can prove very frustrating. Frequent accommodation may result in others devaluing your ideas over time and may cause you to feel that others are taking advantage of you.

A less surrendering style of conflict management is ***compromising***. In the compromising style, people make concessions on an issue while asking others to do the same. This can be a very useful approach when the discussion has reached a deadlock. Although a benefit of this style is that the end result is usually acceptable to all, compromising falls short of meeting the needs of all.

Certainly the most desirable style of conflict management is ***collaborative*** problem solving. In this style, people utilize a high degree of both assertion and cooperation. Although the collaborative style tends to be time-consuming and requires a trusting rapport among professionals, the benefits provided bring new and creative solutions to problems. The collaborative process requires that all members clarify the issues and commonly determine the goals. This shared commitment to collaboration results in less conflict and greater satisfaction for those involved.

Activity 5.4

Use the following questionnaire to see what strategies you use to manage conflict.

THOMAS-KILMANN CONFLICT MODE INSTRUMENT*

Consider situations in which you find your wishes differing from those of another person. How do you usually respond to such situations? Following are several pairs of statements describing possible behavioral responses. For each pair, please circle the "A" or "B" statement that is most characteristic of your own behavior. In many cases, neither the "A" nor the "B" statement may be very typical of your behavior; but please select the response that you would be more likely to use.

1. A. There are times when I let others take responsibility for solving the problem.
   B. Rather than negotiate the things on which we disagree, I try to stress those things upon which we both agree.
2. A. I try to find a compromise solution.
   B. I attempt to deal with all of his/her and my concerns.
3. A. I am usually firm in pursuing my goals.
   B. I might try to soothe the other's feelings and preserve our relationship.
4. A. I try to find a compromise solution.
   B. I sometimes sacrifice my own wishes for the wishes of the other person.
5. A. I consistently seek the other's help in working out a solution.
   B. I try to do what is necessary to avoid useless tensions.
6. A. I try to avoid creating unpleasantness for myself.
   B. I try to win my position.
7. A. I try to postpone the issue until I have had some time to think it over.
   B. I give up some points in exchange for others.
8. A. I am usually firm in pursuing my goals.
   B. I attempt to get all concerns and issues immediately out in the open.
9. A. I feel that differences are not always worth worrying about.
   B. I make some effort to get my way.
10. A. I am firm in pursuing my goals.
    B. I try to find a compromise solution.

---

*Thomas/Kilmann, *Thomas-Kilmann Conflict Mode Instrument*, Copyright 1974, Xicom, Inc., Tuxedo, New York.

11. A I attempt to get all concerns and issues immediately out in the open.
B I might try to soothe the other's feelings and preserve our relationship.
12. A I sometimes avoid taking positions which would create controversy.
B I will let the other person have some of his/her positions if he/she lets me have some of mine.
13. A I propose a middle ground.
B I press to get my points made.
14. A I tell the other person my ideas to ask for his/hers.
B I try to show the other person the logic and benefits of my position.
15. A I might try to soothe the other's feelings and preserve our relationship.
B I try to do what is necessary to avoid tensions.
16 A I try not to hurt the other's feelings.
B I try to convince the other person of the merits of my position.
17. A I am usually firm in pursuing my goals.
B I try to do what is necessary to avoid useless tensions.
18. A If it makes other people happy, I might let them maintain their views.
B I will let other people have some of their positions if they let me have some of mine.
19. A I attempt to get all concerns and issues immediately out in the open.
B I try to postpone the issue until I have had some time to think it over.
20. A I attempt to immediately work through our differences.
B I try to find a fair combination of gains and losses for both of us.
21. A In approaching negotiations, I try to be considerate of the other person's wishes.
B I always lean toward a direct discussion of the problem.
22. A I try to find a position that is intermediate between his/hers and mine.
B I assert my wishes.
23. A I am very often concerned with satisfying all our wishes.
B There are times when I let others take responsibility for solving the problem.
24. A If the other's position seems very important to him/her, I would try to meet his/her wishes.
B I try to get the other person to settle for a compromise.
25. A I try to show the other person the logic and benefits of my position.
B In approaching negotiations, I try to be considerate of the other person's wishes.
26. A I propose a middle ground.
B I am nearly always concerned with satisfying all our wishes.
27. A I sometimes avoid taking positions that would create controversy.
B If it makes other people happy, I might let them maintain their views.
28. A I am usually firm in pursuing my goals.
B I usually seek the other's help in working out a solution.
29. A I propose a middle ground.
B I feel that differences are not always worth worrying about.
30. A I try not to hurt the other's feelings.
B I always share the problem with the other person so that we can work it out.

Scoring the Thomas-Kilmann Conflict Mode Instrument

Circle the letters below which you circled on each item of the questionnaire.

	Competing (forcing)	Collaborating (problem solving)	Compromising (sharing)	Avoiding (withdrawal)	Accommodating
1.				A	B
2.		B	A		
3.	A				B
4.			A		B
5.		A		B	
6.	B			A	
7.			B	A	
8.	A	B			
9.	B			A	
10.	A		B		
11.		A			B
12.			B	A	
13.	B		A		
14.	B	A			
15.				B	A
16.	B				A
17.	A			B	
18.			B		A
19.		A		B	
20.		A	B		
21.		B			A
22.	B		A		
23.		A		B	
24.			B		A
25.	A				B
26.		B	A		
27.				A	B
28.	A	B			
29.			A	B	
30.		B			A

Total number of items circled in each column

________	________	________	________	________
Competing	Collaborating	Compromising	Avoiding	Accommodating

In which column did you receive the highest score?________________

Methods for Resolving Conflict

Resolution of conflicting goals, philosophies, and objectives is the foundation for building collaborative relationships. By following prescribed steps to achieve collaboration, shared commitment and responsibility are the natural byproducts that result from the process. The steps involved require members of interagency teams to share not only their knowledge and expertise, but also their expectations. When entering into interagency collaborations, it is effective to have some agreed upon guidelines that will be followed when conflicts arise. These guidelines should designate the steps the group will take to resolve conflict and the process by which any negotiation of ideas will be conducted.

Separate the People From the Issues

Because people feel strongly about their positions in a conflict, egos become entangled with the issues. Team members need to see themselves as working side by side to attack a mutual problem, rather than each other.

Focus on Interests, Not Positions

Often in a conflict situation, people state their positions, then become determined and argue for that position. In fact, there are underlying interests which are obscured by positions and may never get addressed, if positions are the basis for the discussion. For example, one team member may argue that the team should set a regular meeting schedule, while another may want to set meeting dates as the need to meet arises. There appears to be no easy solution to this conflict.

If we look beyond the positions to the interests, we may find that the first person needs to arrange childcare for her child in order to come to team meetings, and her childcare person needs advance notice. The second person may be pressured by his or her supervisor to spend more time in the office catching up on paperwork. A solution may be to set tentative meeting dates on a regular basis, with the understanding that some may be canceled if they are not needed. Active listening is a powerful tool to let the other side know that you have heard and understood their interests.

Invent Options for Mutual Gain

Setting aside a designated time to brainstorm a number of possible options decreases the urge to make a decision quickly; it also opens the door for new, creative solutions that may not surface if people take an adversarial stance and argue just to win their position.

Insist that the Result Be Based on Some Objective Standard

Rather than bending to someone's will, find some objective way of deciding an issue, or of testing the decision. For example, if two team members disagree on how often a child should be seen for therapy, they may decide to research the literature to see what experience has been suggested to be the optimal number of hours/week for a child of that age and ability to be seen.

Conflict often can be avoided or quickly diffused by adhering to a defined process. First, all members should participate in clarifying the issues. Once the issues have been defined, the expectations and outcomes should be set and agreed upon by everyone involved. This requires clear and open communication. When conflicting attitudes exist, strategies can be used to stimulate new alternatives and options. Among these strategies are: 1) problem solving; 2) brainstorming new options; 3) selecting from among new options; and, if consensus cannot be attained, 4) engaging in negotiations.

Negotiations

Effective negotiations can generate amenable solutions to conflicts. However, to keep negotiations productive and on track, the following activities must occur:

- Suggest new options and alternatives that would prove mutually beneficial.
- Carefully control anger and resistance so that the process is not hindered further.
- Be sure to use objective criteria for making decisions and achieving consensus.
- Use newly offered alternatives to find a solution that may be commonly agreed upon and accepted.

Activity 5.5

Fill out the following questionnaire to evaluate your negotiation skills

How Well Do You Negotiate?*
A Self-Evaluation

Please circle the most appropriate answer.

1. Do you generally go into negotiations well prepared?
    - (a) Very frequently
    - (b) Often
    - (c) Sometimes
    - (d) Not very often
    - (e) Play it by ear

2. How uncomfortable do you feel when facing direct conflict?
    - (a) Very uncomfortable
    - (b) Quite uncomfortable
    - (c) Don't like it but face it
    - (d) Enjoy the challenge somewhat
    - (e) Welcome the opportunity

3. How do you look at negotiation?
    - (a) Highly competitive
    - (b) Mostly competitive but a good part cooperative
    - (c) Mostly cooperative but a good part competitive
    - (d) Very cooperative
    - (e) About half cooperative and competitive

4. What kind of deal do you go for?
    - (a) A good deal for both parties
    - (b) A better deal for you
    - (c) A better deal for him
    - (d) A very good deal for you and better than no deal for him
    - (e) Every person for themselves

5. Do you like to negotiate with merchants (furniture, cars, major appliances)?
    - (a) Love it
    - (b) Like it
    - (c) Neither like nor dislike it
    - (d) Rather dislike it
    - (e) Hate it

6. Are you a good listener?
    - (a) Very good
    - (b) Better than most
    - (c) Average
    - (d) Below average
    - (e) Poor listener

*Karrass, Chester, L. (1989). *Effective negotiating.* Santa Monica, CA: Karrass.

7. How do you feel about ambiguous situations--situations which have a good many pros and cons?
   - (a) Very uncomfortable. Like things one way or another.
   - (b) Fairly uncomfortable.
   - (c) Don't like it but can live with it.
   - (d) Undisturbed. Find it easy to live with.
   - (e) Like it that way. Things are hardly ever one way or another.

8. How would you feel about negotiating a 10% raise with your boss if the average raise in the department is 5%?
   - (a) Don't like it at all. Would avoid it.
   - (b) Don't like it but would make a pass at it reluctantly.
   - (c) Would do it with little apprehension.
   - (d) Make a good case and not afraid to try it.
   - (e) Enjoy the experience and look forward to it.

9. How good is your business judgment?
   - (a) Experience shows that it's very good
   - (b) Good
   - (c) As good as most other executives
   - (d) Not too good
   - (e) I hate to say it, but I guess I'm not quite with it when it comes to business matters.

10. When you have the power, do you use it?
   - (a) I use it to the extent I can
   - (b) I use it moderately without any guilt feelings
   - (c) I use it on behalf of fairness as I see fairness
   - (d) I don't like to use it
   - (e) I take it easy on the other fellow

11. How do you feel about getting personally involved with the other party?
   - (a) I avoid it
   - (b) I'm not quite comfortable
   - (c) Not bad--not good
   - (d) I'm attracted to getting close
   - (e) I go out of my way to get close, I like it that way

12. How sensitive are you to the personal issues facing the opponent in negotiation? (The non-business issues like job security, workload, vacation, getting along with the boss, not rocking the boat.)
   - (a) Very sensitive
   - (b) Quite sensitive
   - (c) Moderately
   - (d) Not too sensitive
   - (e) Hardly sensitive at all

13. How committed are you to the opponent's satisfaction?

- (a) Very committed. I try to see that he doesn't get hurt
- (b) Somewhat committed
- (c) Neutral but I hope he doesn't get hurt
- (d) I'm a bit concerned
- (e) It's everyone for themselves

14. Do you carefully study the limits of the other person's power?

- (a) Very much so
- (b) Quite a bit
- (c) I weigh it
- (d) It's hard to do because I'm not him
- (e) I let things develop at the session

15. How do you feel about making a very low offer when you buy?

- (a) Terrible
- (b) Not too good but I do it sometimes
- (c) I do it only occasionally
- (d) It's hard to do
- (e) I make it a regular practice and feel quite comfortable

16. How do you usually give in?

- (a) Very slowly, if at all
- (b) Moderately slowly
- (c) About at the same pace he does
- (d) I try to move it along a little faster by giving more
- (e) I don't mind giving in hefty chunks and getting to the point

17. How do you feel about taking risks that affect your career?

- (a) Take considerably larger risks than most people
- (b) Somewhat more risk than most
- (c) Somewhat less risk than most
- (d) Take slight risk on occasion but not much
- (e) Rarely take career risks

18. How do you feel with those of higher status?

- (a) Very comfortable
- (b) Quite comfortable
- (c) Mixed feelings
- (d) Somewhat uncomfortable
- (e) Very uncomfortable

19. How well did you prepare for the negotiation of the last house or car you bought?

- (a) Thoroughly
- (b) Quite well
- (c) Moderately
- (d) Not well
- (e) Played it by ear

20. How well do you think when **not** under pressure (compared to your peers)?
(a) Very well
(b) Better than most
(c) Average
(d) A little worse than most
(e) Not too good

21. How would you feel if you had to say, "I don't understand that", four times after four explanations?
(a) Terrible--wouldn't do it
(b) Quite embarrassed
(c) Would feel awkward
(d) Would do it without feeling too badly
(e) Wouldn't hesitate

22. How well do you handle tough questions in negotiations?
(a) Very well
(b) Above average
(c) Average
(d) Below average
(e) Poorly

23. Do you ask probing questions?
(a) Very good at it
(b) Quite good
(c) Average
(d) Not very good
(e) Pretty bad at it

24. Are you close-mouthed about your business?
(a) Very secretive
(b) Quite secretive
(c) Secretive
(d) Tend to say more than I should
(e) Talk too much

25. How confident are you about your knowledge in your own field or profession (compared to your peers)?
(a) Much more confident than most
(b) Somewhat more confident
(c) Average
(d) Somewhat less confident
(e) Not very confident, frankly

26. You are the buyer of some construction services. The design is changed because your spouse wants something different. The contractor now asks for more money for the change. You need him badly because he's well into the job. How do you feel about negotiating the added price?
(a) Jump in with both feet
(b) Ready to work it out but not anxious to
(c) Don't like it but will do it
(d) Dislike it very much
(e) Hate the confrontation

INSTRUCTIONS

To evaluate yourself, check the answer key and add your positive and negative scores separately. Subtract them from each other.

A score between +250 and +340 indicates you are probably negotiating well already. The range of +180 to +250 suggests you have a good measure of the qualities it takes to negotiate successfully. Negative scores, however, show that your skills needed for effective negotiating can use improvement!

ANSWER KEY

1.	(a) + 20	(b) + 15	(c) + 5	(d) - 10	(e) - 20
2.	(a) - 10	(b) - 5	(c) + 10	(d) + 10	(e) - 5
3.	(a) - 15	(b) + 15	(c) + 10	(d) - 15	(e) + 5
4.	(a) + 10	(b) + 5	(c) - 10	(d) + 10	(e) - 5
5.	(a) + 3	(b) + 6	(c) + 6	(d) - 3	(e) - 5
6.	(a) + 15	(b) + 10	(c) 0	(d) - 10	(e) - 15
7.	(a) - 10	(b) - 5	(c) + 5	(d) + 10	(e) + 10
8.	(a) - 10	(b) + 5	(c) + 10	(d) + 13	(e) + 10
9.	(a) + 20	(b) + 15	(c) + 5	(d) - 10	(e) - 20
10.	(a) + 5	(b) + 15	(c) + 10	(d) - 5	(e) 0
11.	(a) - 15	(b) - 10	(c) 0	(d) + 10	(e) + 15
12.	(a) + 16	(b) + 12	(c) + 4	(d) - 5	(e) - 15
13.	(a) + 12	(b) + 6	(c) 0	(d) - 2	(e) - 10
14.	(a) + 15	(b) + 10	(c) + 5	(d) - 5	(e) - 10
15.	(a) - 10	(b) - 5	(c) + 5	(d) + 15	(e) + 15
16.	(a) + 15	(b) + 10	(c) - 3	(d) - 10	(e) - 15
17.	(a) + 5	(b) + 10	(c) 0	(d) - 3	(e) - 10
18.	(a) + 10	(b) + 8	(c) + 3	(d) - 3	(e) - 10
19.	(a) + 15	(b) + 10	(c) + 5	(d) - 5	(e) - 15
20.	(a) + 15	(b) + 10	(c) + 5	(d) 0	(e) - 5
21.	(a) - 8	(b) - 3	(c) + 3	(d) + 8	(e) + 12
22.	(a) + 10	(b) + 8	(c) + 2	(d) - 3	(e) - 10
23.	(a) + 10	(b) + 8	(c) + 3	(d) 0	(e) - 5
24.	(a) + 10	(b) + 10	(c) + 8	(d) - 8	(e) - 15
25.	(a) + 12	(b) + 8	(c) + 4	(d) - 5	(e) - 10
26.	(a) + 15	(b) + 10	(c) 0	(d) - 10	(e) - 15

Stages in the Negotiating Process

The negotiation process can be broken into three stages:

Analysis

In this stage, you are trying to diagnose the situation--to gather information, identify your own interests and those of the other side, note options already on the table, and identify any criteria available as a basis for agreement.

Planning

In this stage, you deal again with the same four elements: generating ideas, thinking about how to handle the "people issues" (hostility, unclear communications, biased perceptions, etc.), prioritizing your own interests, and generating some additional options and criteria for evaluating them.

Discussion

Here the parties talk together, working towards agreement, and the same four elements are the best subjects to discuss. It is important to acknowledge each person's feelings of frustration and anger and difficulties in communication, and to thoroughly understand each other's interests. Acknowledgment and understanding puts everybody in a good position to generate options jointly that will benefit everyone, and to reach agreement on objective standards for resolving opposing interests.

The use of these methods will result in a wise and amicable agreement, efficiently reached.

> ***You cannot solve a problem from within the same consciousness that created that problem... you must think anew.***
>
> ***Einstein***

Activity 5.6

Get into groups of four. Using the stages of Negotiation Process (analysis, planning, and discussion), describe some possible solutions to the problems Polly's parents have with their current service delivery program. One person on the team will play the role of Polly's parents, the other three will play the roles of the case managers from the three different agencies.

Analysis:

Planning:

Discussion:

Notes

APPENDIX C

Infants and Toddlers With Special Needs and Their Families

Collaboration

Northeast Regional Higher Education Institute, 1995

Instructional Module

Infants and Toddlers with Disabilities and Their Families:

Collaboration

PART ONE

I. Objectives
II. Outline
III. Explanatory Materials
IV. Evaluation
V. Resource Material

Instructional Module

Infants and Toddlers with Disabilities and Their Families:

Collaboration

I. Objectives

Participant will be able to:

A. Provide a rationale for collaboration in early intervention

B. Describe barriers to collaboration

C. Describe ways in which individuals manage conflict during collaboration

D. Identify the types of conflict management style used by an individual

E. Describe ways to resolve conflict

II. Outline

A Rationale for collaboration

  1. Improvement of service delivery

  2. Reduction in service duplication

  3. Links among families and professionals for efficient service utilization

B Conflict management styles: benefits and drawbacks

  1 Competitive

  2. Avoidance

  3. Accommodating

  4. Compromising

  5. Collaborative

  6. Activity - How do I mange conflict?

C. Barriers to collaboration

  1. Competitiveness between agencies

  2. Lack of organizational structure for coordination

  3 Technical factors

  4 Personnel

D. Methods for resolving conflict

  1. Steps for addressing conflict

    A. Clarify issues objectively

    B. Set expectations and outcomes

    C. Communicate clearly

    D. Use a variety of strategies

        i. Problem solving
        ii. Brainstorming
        iii. Selecting from options
        iv. Negotiation

2. Negotiation strategies
    A. Separate the people from the problem
    B. Focus on mutual interests
    C. Invent options and alternatives for mutual gain
    D. Manage anger and resistance
    E. Insist on using objective criteria
    F. Select options and alternatives
3. Activity - How well do you negotiate?

III. Explanatory Materials/Expansion of Module Outline

A. Rationale for Collaboration [Transparency 1]

The development of cooperative arrangements among professionals is a common strategy that has been used to improve service delivery (Shenet, 1982). Cooperative arrangements are required by many federal laws, and the desired outcome is the development of more effective interagency agreements. Part H of The Education of the Handicapped Act Amendments of 1986, P.L. 99-457, stipulates that children with disabilities receive "coordinated, comprehensive, multidisciplinary, interagency" services. To ensure that the needs of children with disabilities and their families are being met, it is essential that professionals involved in early intervention learn and develop techniques for developing successful cooperative relations for service delivery. This is because cooperating agencies maintain their own autonomy, as well as their own philosophy and service goals, and these may not be appropriate for the target population. Professionals in the fields of medicine, service coordination, education and social services have all been trained to provide technical expertise in their area of specialty, but few have been taught how to function with other professionals as members of a team. Unfortunately, this model tends to drive most initial attempts to organize services for young children with disabilities and their families.

In order to improve this situation, it has been suggested that the focus of interagency models should shift from cooperative arrangements among agencies to collaborations focused on joint service delivery. It is generally agreed that children with disabilities benefit from the combined expertise of various professionals. Collaboration is a method for blending knowledge from many sources, and has been proven successful in developing comprehensive and coordinated family-centered services. A collaborative strategy is called for in communities where the need and intent is to fundamentally change the way services are designed and delivered (Melaville & Blank, 1991). This requires that the involved agencies agree on a common philosophy and service goal that can only be achieved through joint agency activities. Part H of IDEA assists agencies in moving toward this model by embodying a philosophy of a service delivery system composed of 14 components that can only be achieved through the adoption of such activities (Trohanis, 1989).

There are many benefits to collaborative service delivery models (Elder & Magab, 1980), the most important being an improvement in service delivery to those it serves. Improved services are the result of more efficient and effective use of services, providers, and funding streams across agencies (Audette, 1980; Bailey, 1984). Collaboration also results in the reduction of service duplication (Garland & Linder, 1988; Healy, Keesee, & Smith, 1989), Lastly, collaborative efforts enable parents and service providers to efficiently locate and manage the services required by their family (Bailey, 1989a; Dunst & Trivette, 1988).

B. Conflict Management Styles: Benefits and Drawbacks [Transparency 2]

Collaborative early intervention service systems remain an elusive goal for many states. Yet, the mere recognition of the benefits has not resulted in effective collaborations. Fragmented and isolated services continue to occur by default, rather than by choice, because professionals have not had the opportunity to learn and practice alternative ways of working together (Rainforth, 1990). As a result, professionals and agencies often find themselves in conflict. Conflict is any situation in which one person or group perceives that another person or group is interfering with his or her goal attainment. People tend to approach conflict in a variety of ways. There are five common styles of conflict management, each of which has benefits and drawbacks. The style of conflict management used in a situation often depends on the content and context of the issue.

1. Competitive [Transparency 3]

One style of conflict management is the competitive style. This style is characteristic of people who tend to overpower others with whom they have a conflict. Their goal is to win, regardless of possible negative repercussions. This may be a very appropriate style to utilize when there are ethical concerns or when one is certain they are right. However, some pitfalls of the competitive style are that others may stop engaging in meaningful interactions and collaborative relations can be seriously inhibited or destroyed.

2. Avoidance [Transparency 4]

Avoidance is a second style of conflict management in which people try to avoid conflict by ignoring discrepancies between their own goals and those of others. When conflict is emotionally laden and participants need time to regain their composure, avoidance may be a very appropriate and sensitive methods for handling conflict. However, this approach can give a false sense that all is well. By not addressing the issue head on, conflict can continue to plague the group and may escalate as the result of inaction.

3. Accommodating [Transparency 5]

People who put aside their own needs in order to ensure that others needs are met are engaging in an accommodating style of conflict management. Accommodating is appropriate when the conflict is relatively unimportant or when you are unable to alter the situation of another. The negative ramifications however, can prove very frustrating. Frequent accommodation may result in others devaluing your ideas over time and may cause you to feel that others are taking advantage of you.

4. Compromising [Transparency 6]

A less surrendering style of conflict management is compromising. In the compromising style, people give up some on an issue while asking others to do the same. This can be a very useful approach when there is deadlock over an issue. Although a benefit of this style is that the end result is usually acceptable to all, compromising falls short of meeting the needs of all.

5. Collaborative [Transparency 7]

Certainly the most desirable style of conflict management is collaborative problem solving. In this style people utilize a high degree of both assertion and cooperation. Although the collaborative style tends to be time consuming and requires a trusting rapport among professionals, the benefits are new and creative solutions to problems. The collaborative process requires that all members clarify the issues and commonly determine the goals. This shared commitment of collaboration results in less conflict and greater satisfaction for those involved.

6. Activity [Handout 1]

How do I manage conflict? Use the Thomas Kilmann Questionnaire to see what kind of strategies you use to manage conflict.

C. Barriers to Collaboration [Transparency 8]

Though collaboration may not always be possible, it is certainly the most desirable style for professionals from various disciplines to interact with one another. A more favorable climate for collaboration occurs when agencies, programs or groups share a common philosophy and goal, and the service delivery issue is a priority for each of the service agencies. However, there are several barriers to implementing interagency collaboration. For example, not all participating agencies may agree on the necessity for service improvements. There may be other priorities influencing agencies, such as a budget shortfall, or agencies may already have a history of competition or negative relationships. Nevertheless, federal legislation has clearly created a need to prioritize collaboration, which should facilitate the development of a favorable climate for change to occur.

1 Competitiveness Between Agencies [Transparency 9]

One barrier to interagency collaboration is competitiveness between agencies. Competition between agencies often exists over clients and services. Frequently, the conflicts result from a lack of accurate information about the functions of other agencies. Each agency and program entering into an interagency collaboration has a set of rules and regulations that stipulates target population, budgetary operations, and service structure (including staffing patterns). Agencies and programs must be prepared to share these policies with each other so that barriers to interdependent functioning can be identified and removed. Many existing agency and program policies will need to be evaluated and refined in order to comply with the collaborative requirements of Part H.

2. Lack of Organizational Structure for Coordination [Transparency 10]

Another barrier results from the lack of organizational structure for facilitating coordination between agencies. The goals and philosophies of each agency are individually established. Therefore, existing agency structures are not conducive to jointly planning, teaming, and implementing decisions in a cooperative and coordinated manner. Interagency collaboration requires a process of establishing goals and objectives, clarifying roles, making decisions, and resolving conflicts. The first step necessary for collaborative arrangements to occur is the adoption of a common vision by all involved in the service delivery system. Part H of IDEA ensures that this will occur, because the legislation defines the vision for a collaborative statewide early intervention program. One difficulty in establishing this vision across the various agencies and programs involved in early intervention may be their differing interpretations of the adequacy of the existing system. This obstacle can only be overcome when all participants are willing to participate in a process to ensure open, continued communication, negotiations, and conflict management.

3 Technical Factors [Transparency 11]

Technical factors also interfere with interagency collaboration. Scarce resources of staff, time and money are factors that inhibit agencies from exerting the time and effort to collaborate with other agencies. Logistical issues, such as distance and geography, are common excuses for agencies to not work collaboratively. Interagency collaborative efforts require new fiscal arrangements to ensure the development and delivery of services. Resources of all kinds (fiscal, staff, time, in-kind services) will have to be pooled to establish the most efficient system for delivery of services. In an age of shrinking resources, interagency collaborations are often the only way to guarantee the development of an integrated service system. Early intervention is one area in which resources must be pooled and funding levels increased. Only then will states be able to implement services in conjunction with the spirit of Part H.

4. Personnel [Transparency 12]

As in any situation, the attitudes of personnel can present the greatest barrier to interagency collaboration. Individuals who are resistant to change will find many reasons why collaboration between agencies cannot occur. Frequently, such resistance is indicative of a lack of commitment to the more global needs of children and families, a failure to acknowledge the strengths of other disciplines, or a lack of support from administrative powers. The people involved in the creation, development, and implementation of the interagency service system are a critical factor in the ultimate success of the collaborative model. Most important is an effective leader. A leader must be able to both establish and help sell the vision to all participants. He or she must also be able to translate the vision into the reality of service delivery. Also important is the competence and commitment of the other participants, both to policymaking and service delivery. All participants should be provided access to support and training as their roles change with the development and implementation of a collaborative service delivery system.

D. Methods for Resolving Conflict

Resolution of conflicting goals, philosophies, and objectives is the foundation for building collaborative relationships between agencies. By following prescribed steps to achieve collaboration, shared commitment and responsibility are the natural by product that result from the process. The steps involved require members of interagency teams to share not only their knowledge and expertise, but also their expectations. When entering into interagency collaborations, it is effective to have some agreed upon guidelines that will be followed when conflicts arise. These guidelines should designate the steps the group will take to resolve conflict and the process by which any negotiation of ideas will be conducted.

1. Steps for Addressing Conflict [Transparency 13]

Conflict can often be avoided or quickly diffused by adhering to a defined process. First, all members should participate in clarifying the issues. Once the issues have been defined, the expectations and outcomes should be set and agreed upon by everyone involved. This requires clear and open communication. When conflicting attitudes exist, strategies can be used to stimulate new alternatives and options. Among these strategies are problem solving, brainstorming new options, selecting from among new options, and if consensus cannot be attained, engaging in negotiations.

2. Negotiation Strategies [Transparency 14]

Effective negotiations can generate amenable solutions to conflicts. However, to keep negotiations productive and on track, the following must occur.

- Separate the people from the issues, so that the appropriate focus is maintained.
- Concentrate on areas of mutual interest, to stimulate additional areas of mutual concern and agreement.

- Suggest new options and alternatives that would prove mutually beneficial.

- Carefully control anger and resistance so that the process is not hindered further.

- Be sure to use objective criteria for making decisions and achieving consensus.

- Use newly offered alternatives to find a solution that may be commonly agreed upon and accepted.

A positive atmosphere of communication and trust among the participants must be maintained throughout the interagency collaborative process (Johnson & Johnson, 1987). This occurs when the focus of the collaboration is on the people involved, rather than on the individual agency and program requirements (Fisher & Brown, 1989). This focus should include both the consumers of the services (families and children) and the service providers. The collaborative vision can be defined as "relationship driven," as the participants focus on improving the services or system for people, rather than for agencies and programs. The end result of developing these qualities is that of increased problem solving for the team and a common desire to find mutually beneficial solutions. This collaborative model is at the very heart of early intervention under Part H of IDEA.

3. Activity [Handout 2]

Use this Dr. Chester L. Karrass' self evaluation checklist to determine how well you negotiate.

To evaluate yourself, check the answer key and add your positive and negative scores separately. Subtract them from each other.

A score between +250 and +340 indicates you are probably negotiating well already. The range of +180 to +250 suggests you have a good measure of the qualities it takes to negotiate successfully. Negative scores, however, show that your skills needed for effective negotiating can use improvement!

ANSWER KEY

1.	(a) +20	(b) +15	(c) + 5	(d) - 10	(e) - 20
2.	(a) - 10	(b) - 5	(c) +10	(d) +10	(e) - 5
3.	(a) - 15	(b) +15	(c) +10	(d) - 15	(e) + 5
4.	(a) +10	(b) + 5	(c) - 10	(d) +10	(e) - 5
5.	(a) + 3	(b) + 6	(c) + 6	(d) - 3	(e) - 5
6.	(a) +15	(b) +10	(c) 0	(d) - 10	(e) - 15
7.	(a) - 10	(b) - 5	(c) + 5	(d) +10	(e) +10
8.	(a) - 10	(b) + 5	(c) +10	(d) +13	(e) +10
9.	(a) +20	(b) +15	(c) + 5	(d) - 10	(e) - 20
10.	(a) + 5	(b) +15	(c) +10	(d) - 5	(e) 0
11.	(a) - 15	(b) - 10	(c) 0	(d) +10	(e) +15
12.	(a) +16	(b) +12	(c) + 4	(d) - 5	(e) - 15
13.	(a) +12	(b) + 6	(c) 0	(d) - 2	(e) - 10
14.	(a) +15	(b) +10	(c) + 5	(d) - 5	(e) - 10
15.	(a) - 10	(b) - 5	(c) + 5	(d) +15	(e) +15
16.	(a) +15	(b) +10	(c) - 3	(d) - 10	(e) - 15
17.	(a) + 5	(b) +10	(c) 0	(d) - 3	(e) - 10
18.	(a) +10	(b) + 8	(c) + 3	(d) - 3	(e) - 10
19.	(a) +15	(b) +10	(c) + 5	(d) - 5	(e) - 15
20.	(a) +15	(b) +10	(c) + 5	(d) 0	(e) - 5
21.	(a) - 8	(b) - 3	(c) + 3	(d) + 8	(e) +12
22.	(a) +10	(b) + 8	(c) + 2	(d) - 3	(e) - 10
23.	(a) +10	(b) + 8	(c) + 3	(d) 0	(e) - 5
24.	(a) +10	(b) +10	(c) + 8	(d) - 8	(e) - 15
25.	(a) +12	(b) + 8	(c) + 4	(d) - 5	(e) - 10
26.	(a) +15	(b) +10	(c) 0	(d) - 10	(e) - 15

IV. Evaluation

1. Describe the rationale for collaboration in early intervention. Use the case study involving Polly **[Handout #3]** to support why a collaborative model is key to delivering early intervention services.

2. Describe the four barriers to collaboration. For each barrier describe at least one strategy that could be used to overcome the barrier.

3. Describe the different types of conflict management skill, including the strengths and weakness of each approach.

V. Suggested Reference

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Instructional Module

Infants and Toddlers with Disabilities and Their Families:

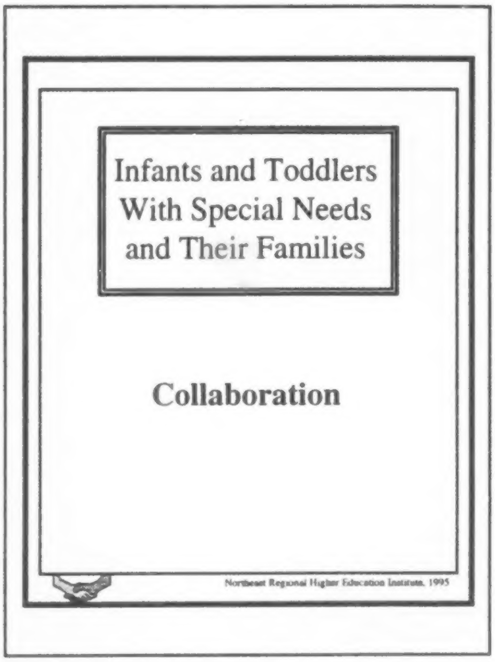
Collaboration

PART TWO

Supporting Materials

I. Lecture Notes
II. Student Handouts for Note-Taking
III. Additional Student Handouts
IV. Transparency Samples

Faculty Presentation Guide



Infants and Toddlers
With Special Needs
and Their Families

Collaboration

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Lecture Notes

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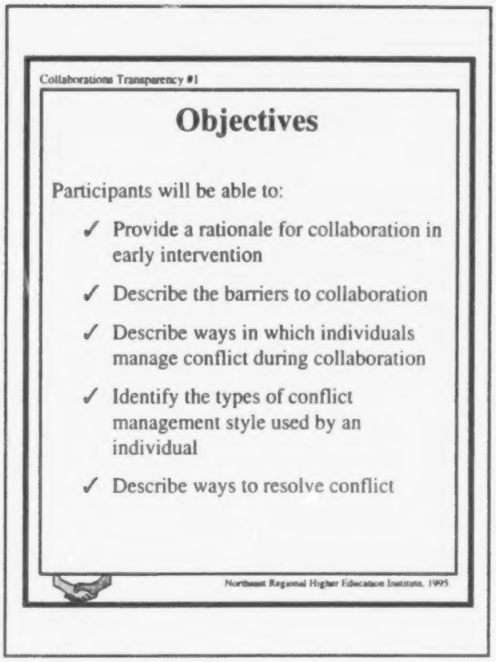

Collaborations Transparency #1

Objectives

Participants will be able to:

- ✓ Provide a rationale for collaboration in early intervention
- ✓ Describe the barriers to collaboration
- ✓ Describe ways in which individuals manage conflict during collaboration
- ✓ Identify the types of conflict management style used by an individual
- ✓ Describe ways to resolve conflict

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Lecture Notes

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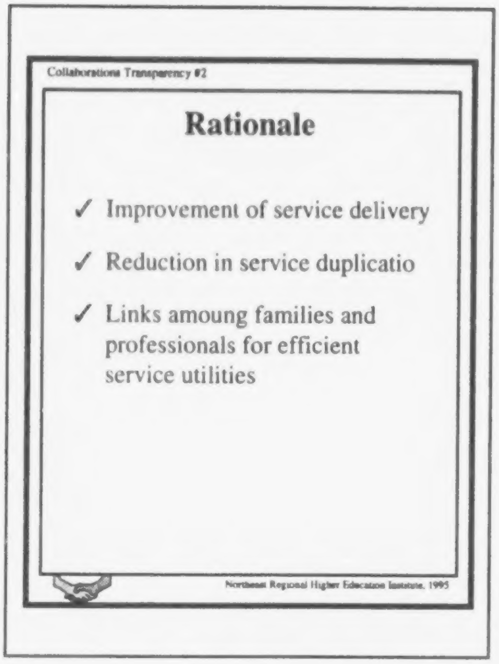

Collaborations Transparency #2

Rationale

- ✓ Improvement of service delivery
- ✓ Reduction in service duplicatio
- ✓ Links amoung families and professionals for efficient service utilities

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Lecture Notes

Faculty Presentation Guide

Collaborations Transparency #3

Conflict Management Styles

- ✓ Competitive
- ✓ Avoidance
- ✓ Accommodating
- ✓ Compromising
- ✓ Collaborative

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Lecture Notes

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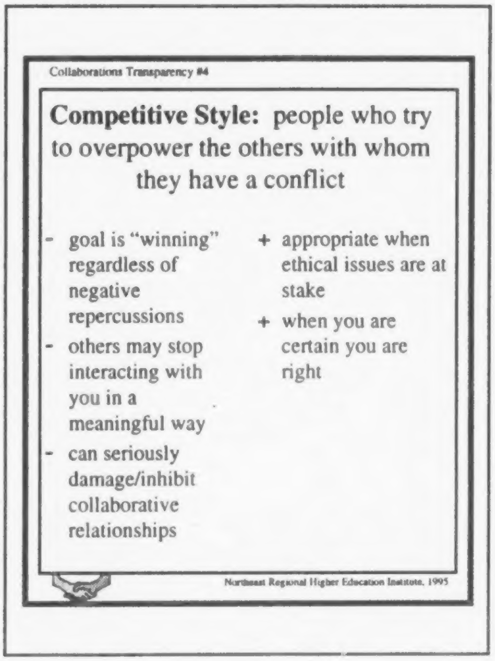

Collaborations Transparency #4

Competitive Style: people who try to overpower the others with whom they have a conflict

- goal is "winning" regardless of negative repercussions
- others may stop interacting with you in a meaningful way
- can seriously damage/inhibit collaborative relationships

+ appropriate when ethical issues are at stake
+ when you are certain you are right

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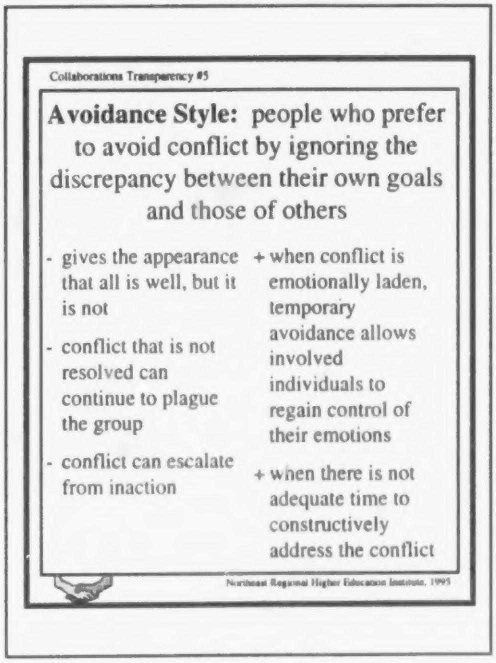

Collaborations Transparency #5

Avoidance Style: people who prefer to avoid conflict by ignoring the discrepancy between their own goals and those of others

- gives the appearance that all is well, but it is not
- conflict that is not resolved can continue to plague the group
- conflict can escalate from inaction

+ when conflict is emotionally laden, temporary avoidance allows involved individuals to regain control of their emotions
+ when there is not adequate time to constructively address the conflict

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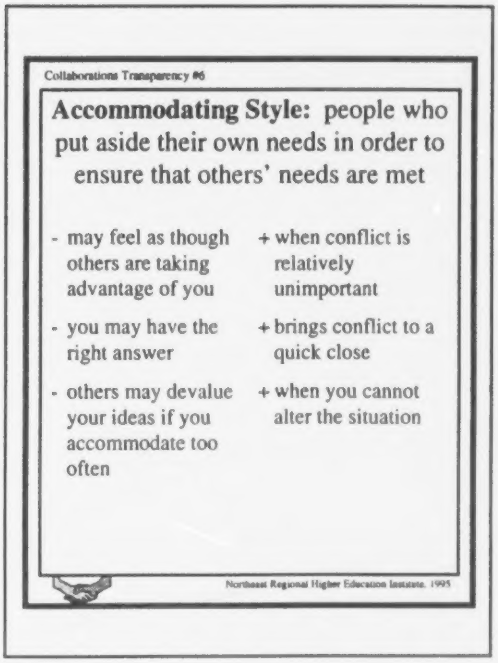

Collaborations Transparency #6

Accommodating Style: people who put aside their own needs in order to ensure that others' needs are met

- may feel as though others are taking advantage of you
- you may have the right answer
- others may devalue your ideas if you accommodate too often

+ when conflict is relatively unimportant
+ brings conflict to a quick close
+ when you cannot alter the situation

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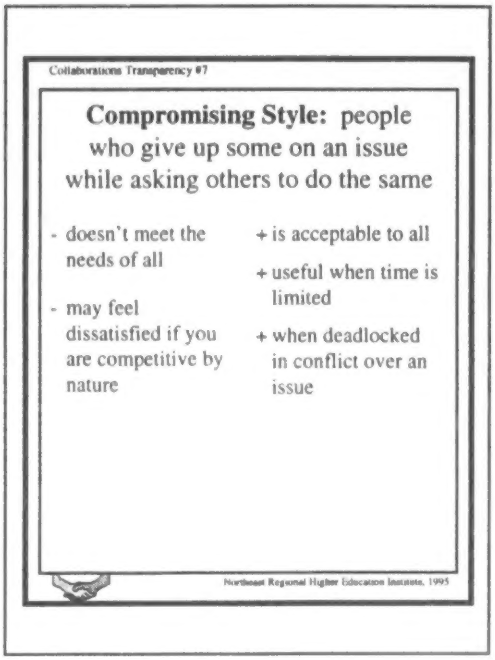

Collaborations Transparency #7

Compromising Style: people who give up some on an issue while asking others to do the same

- doesn't meet the needs of all	+ is acceptable to all
- may feel dissatisfied if you are competitive by nature	+ useful when time is limited
	+ when deadlocked in conflict over an issue

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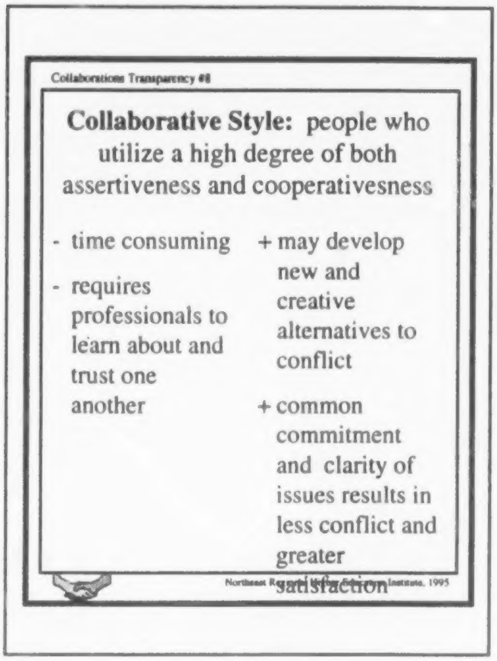

Collaborations Transparency #8

Collaborative Style: people who utilize a high degree of both assertiveness and cooperativesness

- time consuming
- requires professionals to learn about and trust one another

+ may develop new and creative alternatives to conflict
+ common commitment and clarity of issues results in less conflict and greater satisfaction

Northeast Regional Higher Education Institute, 1995

Lecture Notes

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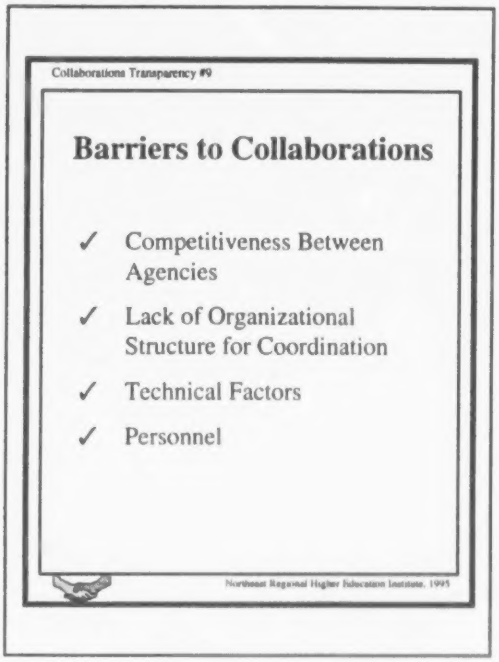

Collaborations Transparency #9

Barriers to Collaborations

- ✓ Competitiveness Between Agencies
- ✓ Lack of Organizational Structure for Coordination
- ✓ Technical Factors
- ✓ Personnel

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Lecture Notes

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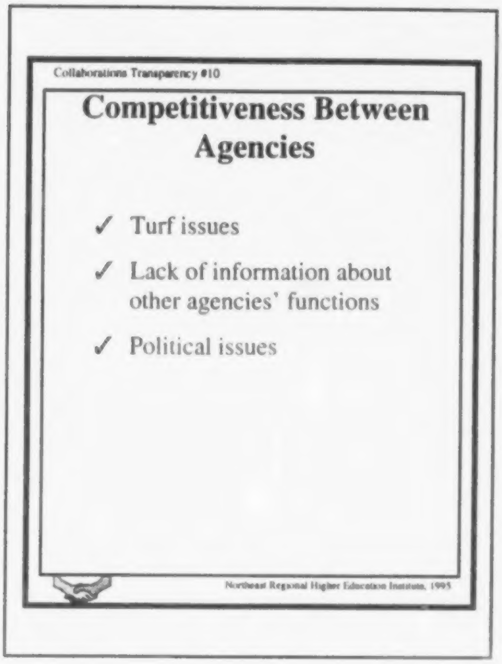

Collaborations Transparency #10

Competitiveness Between Agencies

- ✓ Turf issues
- ✓ Lack of information about other agencies' functions
- ✓ Political issues

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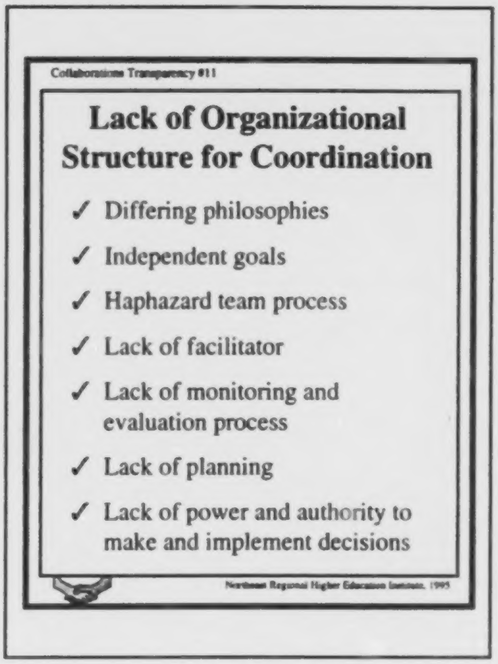

Collaborations Transparency #11

Lack of Organizational Structure for Coordination

- ✓ Differing philosophies
- ✓ Independent goals
- ✓ Haphazard team process
- ✓ Lack of facilitator
- ✓ Lack of monitoring and evaluation process
- ✓ Lack of planning
- ✓ Lack of power and authority to make and implement decisions

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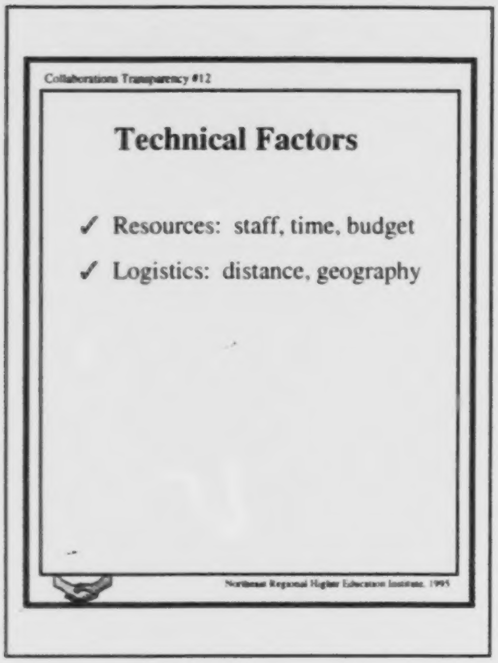

Collaborations Transparency #12

Technical Factors

- ✓ Resources: staff, time, budget
- ✓ Logistics: distance, geography

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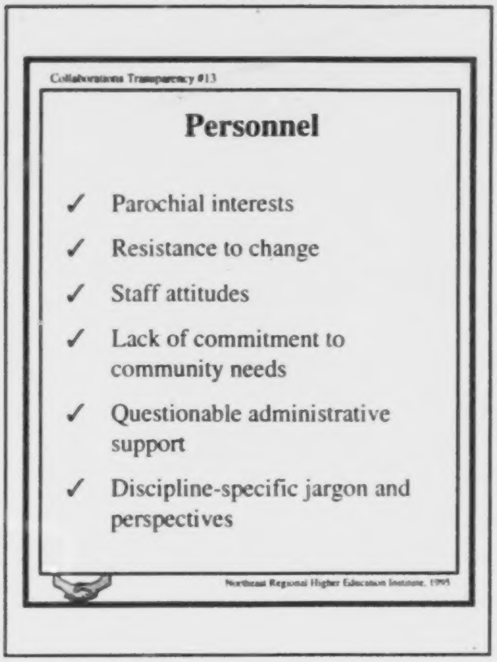

Collaborations Transparency #13

Personnel

- ✓ Parochial interests
- ✓ Resistance to change
- ✓ Staff attitudes
- ✓ Lack of commitment to community needs
- ✓ Questionable administrative support
- ✓ Discipline-specific jargon and perspectives

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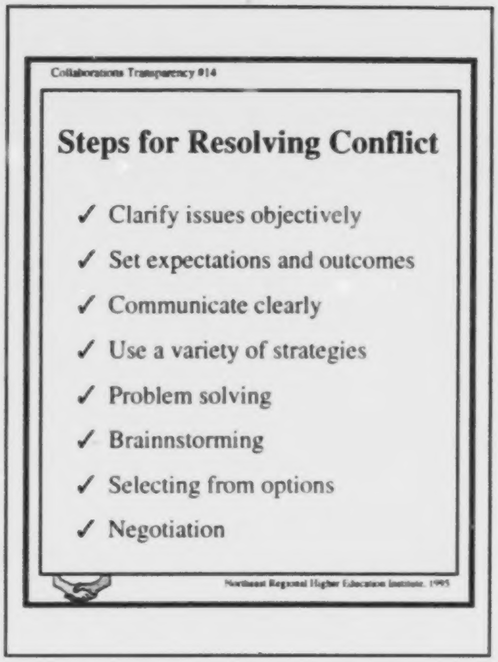

Collaborations Transparency #14

Steps for Resolving Conflict

- ✓ Clarify issues objectively
- ✓ Set expectations and outcomes
- ✓ Communicate clearly
- ✓ Use a variety of strategies
- ✓ Problem solving
- ✓ Brainnstorming
- ✓ Selecting from options
- ✓ Negotiation

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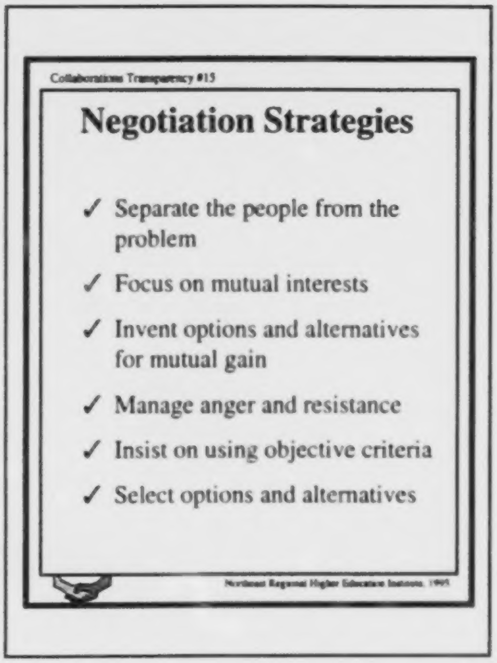

Collaborations Transparency #15

Negotiation Strategies

- ✓ Separate the people from the problem
- ✓ Focus on mutual interests
- ✓ Invent options and alternatives for mutual gain
- ✓ Manage anger and resistance
- ✓ Insist on using objective criteria
- ✓ Select options and alternatives

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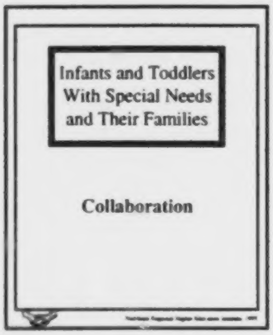
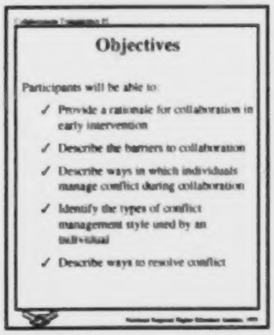
Lecture Notes

Student Handouts- Collaborations



Infants and Toddlers
With Special Needs
and Their Families

Collaboration



Objectives

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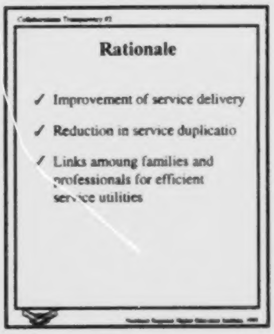

Rationale

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- ✓ Reduction in service duplicatio
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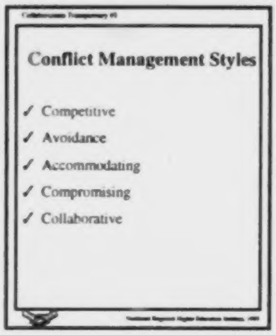
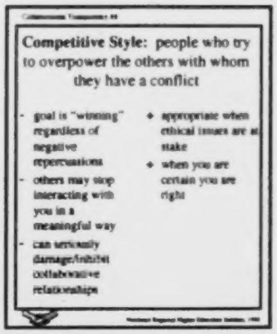


Conflict Management Styles

- ✓ Competitive
- ✓ Avoidance
- ✓ Accommodating
- ✓ Compromising
- ✓ Collaborative



Competitive Style: people who try to overpower the others with whom they have a conflict

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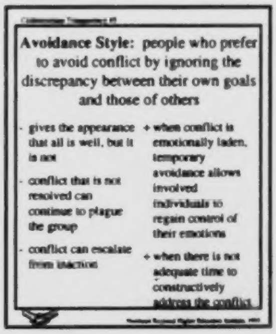

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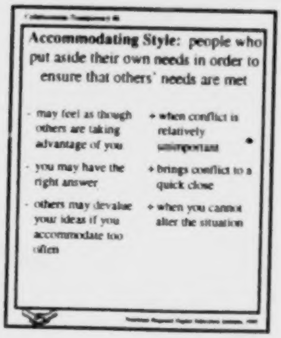
Student Handouts- Collaborations

Page # 3



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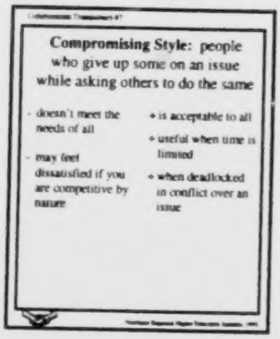

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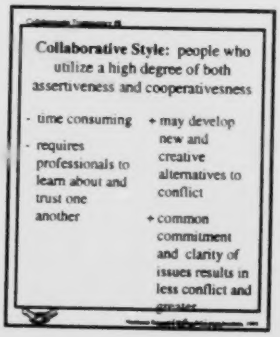

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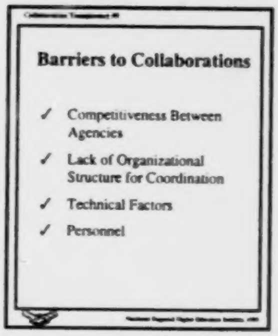
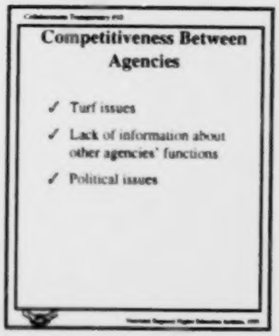
Student Handouts- Collaborations



Barriers to Collaborations

- ✓ Competitiveness Between Agencies
- ✓ Lack of Organizational Structure for Coordination
- ✓ Technical Factors
- ✓ Personnel



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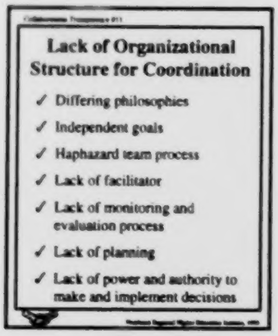

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- ✓ Lack of power and authority to make and implement decisions

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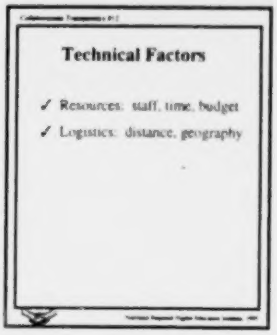

Technical Factors

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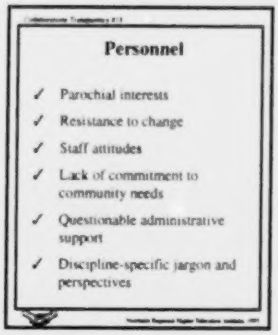
- ✓ Logistics: distance, geography



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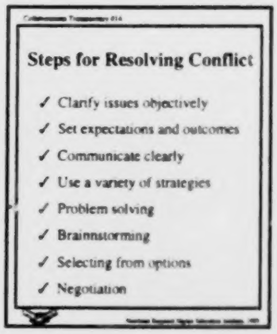
- ✓ Questionable administrative support
- ✓ Discipline-specific jargon and perspectives



Steps for Resolving Conflict

- ✓ Clarify issues objectively
- ✓ Set expectations and outcomes
- ✓ Communicate clearly
- ✓ Use a variety of strategies
- ✓ Problem solving
- ✓ Brainstorming
- ✓ Selecting from options
- ✓ Negotiation

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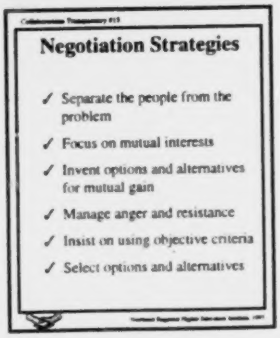

Negotiation Strategies

- ✓ Separate the people from the problem
- ✓ Focus on mutual interests
- ✓ Invent options and alternatives for mutual gain
- ✓ Manage anger and resistance
- ✓ Insist on using objective criteria
- ✓ Select options and alternatives

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Handout # 1

THOMAS-KILMANN CONFLICT MODE INSTRUMENT*

Consider situations in which you find your wishes differing from those of another person. How do you usually respond to such situations? Following are several pairs of statements describing possible behavioral responses. For each pair, please circle the "A" or "B" statement that is most characteristic of your own behavior. In many cases, neither the "A" nor the "B" statement may be very typical of your behavior; but please select the response that you would be more likely to use.

1. A. There are times when I let others take responsibility for solving the problem.
   B. Rather than negotiate the things on which we disagree, I try to stress those things upon which we both agree.
2. A. I try to find a compromise solution.
   B. I attempt to deal with all of his/her and my concerns.
3. A. I am usually firm in pursuing my goals.
   B. I might try to soothe the other's feelings and preserve our relationship.
4. A. I try to find a compromise solution.
   B. I sometimes sacrifice my own wishes for the wishes of the other person.
5. A. I consistently seek the other's help in working out a solution.
   B. I try to do what is necessary to avoid useless tensions.
6. A. I try to avoid creating unpleasantness for myself.
   B. I try to win my position.
7. A. I try to postpone the issue until I have had some time to think it over.
   B. I give up some points in exchange for others.
8. A. I am usually firm in pursuing my goals.
   B. I attempt to get all concerns and issues immediately out in the open.
9. A. I feel that differences are not always worth worrying about.
   B. I make some effort to get my way.
10. A. I am firm in pursuing my goals.
    B. I try to find a compromise solution.
11. A. I attempt to get all concerns and issues immediately out in the open.
    B. I might try to soothe the other's feelings and preserve our relationship.
12. A. I sometimes avoid taking positions which would create controversy.
    B. I will let the other person have some of his/her positions if he/she lets me have some of mine.
13. A. I propose a middle ground.
    B. I press to get my points made.
14. A. I tell the other person my ideas to ask for his/hers.
    B. I try to show the other person the logic and benefits of my position.

15. A. I might try to soothe the other's feelings and preserve our relationship.
B. I try to do what is necessary to avoid tensions.

16 A. I try not to hurt the other's feelings.
B. I try to convince the other person of the merits of my position.

17. A. I am usually firm in pursuing my goals.
B. I try to do what is necessary to avoid useless tensions.

18. A. If it makes other people happy, I might let them maintain their views.
B. I will let other people have some of their positions if they let me have some of mine.

19. A. I attempt to get all concerns and issues immediately out in the open.
B. I try to postpone the issue until I have had some time to think it over.

20. A. I attempt to immediately work through our differences.
B. I try to find a fair combination of gains and losses for both of us.

21. A. In approaching negotiations, I try to be considerate of the other person's wishes.
B. I always lean toward a direct discussion of the problem.

22. A. I try to find a position that is intermediate between his/hers and mine.
B. I assert my wishes.

23. A. I am very often concerned with satisfying all our wishes.
B. There are times when I let others take responsibility for solving the problem.

24. A. If the other's position seems very important to him/her, I would try to meet his/her wishes.
B. I try to get the other person to settle for a compromise.

25. A. I try to show the other person the logic and benefits of my position.
B. In approaching negotiations, I try to be considerate of the other person's wishes.

26. A. I propose a middle ground.
B. I am nearly always concerned with satisfying all our wishes.

27. A. I sometimes avoid taking positions that would create controversy.
B. If it makes other people happy, I might let them maintain their views.

28. A. I am usually firm in pursuing my goals.
B. I usually seek the other's help in working out a solution.

29. A. I propose a middle ground.
B. I feel that differences are not always worth worrying about.

30. A. I try not to hurt the other's feelings.
B. I always share the problem with the other person so that we can work it out.

---

*Thomas/Kilmann, *Thomas-Kilmann Conflict Mode Instrument,* Copyright 1974, Xicom, Inc., Tuxedo, New York.

Scoring the Thomas-Kilmann Conflict Mode Instrument

Circle the letters below which you circled on each item of the questionnaire.

	Competing (forcing)	Collaborating (problem solving)	Compromising (sharing)	Avoiding (withdrawal)	Accommodating
1.				A	B
2.		B	A		
3.	A				B
4.			A		B
5.		A		B	
6.	B			A	
7.			B	A	
8.	A	B			
9.	B			A	
10.	A		B		
11.		A			B
12.			B	A	
13.	B		A		
14.	B	A			
15.				B	A
16.	B				A
17.	A			B	
18.			B		A
19.		A		B	
20.		A	B		
21.		B			A
22.	B		A		
23.		A		B	
24.			B		A
25.	A				B
26.		B	A		
27.				A	B
28.	A	B			
29.			A	B	
30.		B			A

Total number of items circled in each column

________	________	________	________	________
Competing	Collaborating	Compromising	Avoiding	Accommodating

In which column did you receive the highest score?

Handout #2

HOW WELL DO YOU NEGOTIATE?

A Self-Evaluation

Please circle the most appropriate answer.

1. Do you generally go into negotiations well prepared?
   (a) Very frequently
   (b) Often
   (c) Sometimes
   (d) Not very often
   (e) Play it by ear

2. How uncomfortable do you feel when facing direct conflict?
   (a) Very uncomfortable
   (b) Quite uncomfortable
   (c) Don't like it but face it
   (d) Enjoy the challenge somewhat
   (e) Welcome the opportunity

3. How do you look at negotiation?
   (a) Highly competitive
   (b) Mostly competitive but a good part cooperative
   (c) Mostly cooperative but a good part competitive
   (d) Very cooperative
   (e) About half cooperative and competitive

4. What kind of deal do you go for?
   (a) A good deal for both parties
   (b) A better deal for you
   (c) A better deal for him
   (d) A very good deal for you and better than no deal for him
   (e) Every person for themselves

5. Do you like to negotiate with merchants (furniture, cars, major appliances)?
   (a) Love it
   (b) Like it
   (c) Neither like nor dislike it
   (d) Rather dislike it
   (e) Hate it

6. Are you a good listener?
   (a) Very good
   (b) Better than most
   (d) Below average
   (e) Poor listener

7. How do you feel about ambiguous situations - situations which have a good many pros and cons?
   (a) Very uncomfortable. Like things one way or another.
   (b) Fairly uncomfortable.
   (c) Don't like it but can live with it.
   (d) Undisturbed. Find it easy to live with.
   (e) Like it that way. Things are hardly ever one way or another.

8. How would you feel about negotiating a 10% raise with your boss if the average raise in the department is 5%?
(a) Don't like it at all. Would avoid it.
(b) Don't like it but would make a pass at it reluctantly.
(c) Would do it with little apprehension.
(d) Make a good case and not afraid to try it.
(e) Enjoy the experience and look forward to it.

9. How good is your business judgment?
(a) Experience show that it's very good
(b) Good
(c) As good as most other executives
(d) Not too good
(e) I hate to say it, but I guess I'm not quite with it when it comes to business matters

10. When you have the power, do you use it?
(a) I use it to the extent I can
(b) I use it moderately without any guilt feelings
(c) I use it on behalf of fairness as I see fairness
(d) I don't like to use it
(e) I take it easy on the other fellow

11. How do you feel about getting personally involved with the other party?
(a) I avoid it
(b) I'm not quite comfortable
(c) Not bad - not good
(d) I'm attracted to getting close to him
(e) I go out of my way to get close. I like it that way.

12. How sensitive are you to the personal issues facing the opponent in negotiation? (The nonbusiness issues like job security, workload, vacation, getting along with the boss, not rocking the boat.)
(a) Very sensitive
(b) Quite sensitive
(c) Moderately
(d) Not too sensitive
(e) Hardly sensitive at all

13. How committed are you to the opponent's satisfaction?
(a) Very committed. I try to see that he doesn't get hurt
(b) Somewhat committed
(c) Neutral but I hope he doesn't get hurt
(d) I'm a bit concerned
(e) It's everyone for themselves

14. Do you carefully study the limits of the other person's power?
(a) Very much so
(b) Quite a bit
(c) I weigh it
(d) It's hard to do because I'm not him
(e) I let things develop at the session

15. How do you feel about making a very low offer when you buy?
    (a) Terrible
    (b) Not too good but I do it sometimes
    (c) I do it only occasionally
    (d) It's hard to do because I'm not him
    (e) I make it a regular practice and feel quite comfortable

16. How do you usually give in?
    (a) Very slowly, if at all
    (b) Moderately slowly
    (c) About at the same pace he does
    (d) I try to move it along a little faster by giving more
    (e) I don't mind giving in hefty chunks and getting to the point

17. How do you feel about taking risks that affect your career?
    (a) Take considerably larger risks than most people
    (b) Somewhat more risk than most
    (c) Somewhat less risk than most
    (d) Take slight risk on occasion but not much
    (e) Rarely take career risks

18. How do you feel with those of higher status?
    (a) Very comfortable
    (b) Quite comfortable
    (c) Mixed feelings
    (d) Somewhat uncomfortable
    (e) Very uncomfortable

19. How well did you prepare for the negotiation of the last house or car you bought?
    (a) Thoroughly
    (b) Quite well
    (c) Moderately
    (d) Not well
    (e) Played it by ear

20. How well do you think when **not** under pressure (compared to your peers)?
    (a) Very well
    (b) Better than most
    (c) Average
    (d) A little worse than most
    (e) Not too good

21. How would you feel if you had to say, "I don't understand that", four times after four explanations?
    (a) Terrible - wouldn't do it
    (b) Quite embarrassed
    (c) Would feel awkward
    (d) Would do it without feeling too badly
    (e) Wouldn't hesitate

22. How well do you handle tough questions in negotiations?
    (a) Very well
    (b) Above average
    (c) Average
    (d) Below average
    (e) Poorly

23. Do you ask probing questions:
(a) Very good at it
(b) Quite good
(c) Average
(d) Not very good
(e) Pretty bad at it

24. Are you close-mouthed about your business?
(a) Very secretive
(b) Quite secretive
(c) Secretive
(d) Tend to say more than I should
(e) Talk too much

25. How confident are you about your knowledge in your own field or profession (compared to your peers)?
(a) Much more confident than most
(b) Somewhat more confident
(c) Average
(d) Somewhat less confident
(e) Not very confident, frankly

26. You are the buyer of some construction services. The design is changed because your spouse wants something different. The contractor now asks for more money for the change. You need him badly because he's well into the job. How do you feel about negotiating the added price?
(a) Jump in with both feet
(b) Ready to work it out but not anxious to
(c) Don't like it but will do it
(d) Dislike it very much
(e) Hate the confrontation

Handout 2-5

INSTRUCTIONS

To evaluate yourself, check the answer key and add your positive and negative scores separately. Subtract them from each other.

A score between +250 and +340 indicates you are probably negotiating well already. The range of +180 to +250 suggests you have a good measure of the qualities it takes to negotiate successfully. Negative scores, however, show that your skills needed for effective negotiating can use improvement!

ANSWER KEY

1.	(a) +20	(b) +15	(c) + 5	(d) - 10	(e) - 20
2.	(a) - 10	(b) - 5	(c) +10	(d) +10	(e) - 5
3.	(a) - 15	(b) +15	(c) +10	(d) - 15	(e) + 5
4.	(a) +10	(b) + 5	(c) - 10	(d) +10	(e) - 5
5.	(a) + 3	(b) + 6	(c) + 6	(d) - 3	(e) - 5
6.	(a) +15	(b) +10	(c) 0	(d) - 10	(e) - 15
7.	(a) - 10	(b) - 5	(c) + 5	(d) +10	(e) +10
8.	(a) - 10	(b) + 5	(c) +10	(d) +13	(e) +10
9.	(a) +20	(b) +15	(c) + 5	(d) - 10	(e) - 20
10.	(a) + 5	(b) +15	(c) +10	(d) - 5	(e) 0
11.	(a) - 15	(b) - 10	(c) 0	(d) +10	(e) +15
12.	(a) +16	(b) +12	(c) + 4	(d) - 5	(e) - 15
13.	(a) +12	(b) + 6	(c) 0	(d) - 2	(e) - 10
14.	(a) +15	(b) +10	(c) + 5	(d) - 5	(e) - 10
15.	(a) - 10	(b) - 5	(c) + 5	(d) +15	(e) +15
16.	(a) +15	(b) +10	(c) - 3	(d) - 10	(e) - 15
17.	(a) + 5	(b) +10	(c) 0	(d) - 3	(e) - 10
18.	(a) +10	(b) + 8	(c) + 3	(d) - 3	(e) - 10
19.	(a) +15	(b) +10	(c) + 5	(d) - 5	(e) - 15
20.	(a) +15	(b) +10	(c) + 5	(d) 0	(e) - 5
21.	(a) - 8	(b) - 3	(c) + 3	(d) + 8	(e) +12
22.	(a) +10	(b) + 8	(c) + 2	(d) - 3	(e) - 10
23.	(a) +10	(b) + 8	(c) + 3	(d) 0	(e) - 5
24.	(a) +10	(b) +10	(c) + 8	(d) - 8	(e) - 15
25.	(a) +12	(b) + 8	(c) + 4	(d) - 5	(e) - 10
26.	(a) +15	(b) +10	(c) 0	(d) - 10	(e) - 15

Handout #3

Child: Polly (18 months)

Other Children: None

Parents: Brenda (28 years old)
Mark (29 years old)

Polly is 18 months old and lives with her family in central Connecticut. She was born prematurely, and is the sole survivor of a set of triplets. Polly was hospitalized for 13 months following birth. Her medical and developmental conditions include:

- Brain damage
- Heart problems
- Frequent infections that result in hospitalizations
- Dependency on oxygen
- Self-abusive episodes, including severe head banging

Because of her condition, Polly and her family have been receiving a variety of services, including:

- Health care through her primary pediatrician
- Occupational therapy once per week
- Speech therapy once every other week
- Physical therapy once per week
- Home education through a Regional Education Service Center (RESC) twice per week
- Sixteen hours a day of home nursing care
- Medical supply vendors delivering special formulas and oxygen
- Specialty care at the hospital through a variety of clinics

The family regularly has many professionals coming to and going from their house. During the five months that Polly has been home services have been provided by five therapists, two teachers, ten nurses, and a hospital-based team comprised of a physician, two nurses, a psychologist, a full range of therapists, and a social worker. Also assigned to Polly's care are two social workers, three program supervisors, and three case managers from three separate agencies.

It is not surprising that Polly's parents are often caught in the middle of conflicts among the various professionals; each of whom seems to have a different opinion about Polly's needs, appropriate treatments, payment options, and service schedules. For example, each of the three case managers gave the family different information about their eligibility for various sources of public funding, including the Medicaid Waiver. As a result, their application for benefits was delayed and they had to pay several thousand dollars out-of-pocket for some of Polly's care. In addition, the nursing agency and the different therapists disagree about the amount of therapy Polly needs, and therefore do not cooperate with one another. Because there is no coordination among the service agencies and providers, the family finds that the services Polly receives often cause confusion in their lives. A week in their house looks like this:

- Monday: 16 hours nursing/teacher/supervisor/Department of Income Maintenance case manager
- Tuesday: 16 hours nursing/OT/DMR case manager
- Wednesday: 16 hours nursing/teacher/ clinic visit at tertiary care hospital/PT
- Thursday: 16 hours nursing/PT/vendor delivery/nurse supervisor/ teacher
- Friday: 16 hours nursing/speech therapy/adaptive equipment fitting at tertiary care hospital
- Saturday: 16 hours nursing
- Sunday: 16 hours nursing

The family has concluded that caring for Polly is not the primary cause of their stress, rather that the multiple layers of fragmented services are causing much havoc in their family. Polly's parents are now seeking out-of-home placement for her because they feel the need to put some order back into their lives. Neither parent feels "functional" with so many people in and out of the house. In Polly's case, one of the intents of P.L. 99-457, reducing the likelihood of institutionalization, has not been realized.

Infants and Toddlers With Special Needs and Their Families

Collaboration

Northeast Regional Higher Education Institute, 1995

Collaborations Transparency #1

Objectives

Participants will be able to:

- ✓ Provide a rationale for collaboration in early intervention
- ✓ Describe the barriers to collaboration
- ✓ Describe ways in which individuals manage conflict during collaboration
- ✓ Identify the types of conflict management style used by an individual
- ✓ Describe ways to resolve conflict

Northeast Regional Higher Education Institute, 1995

Rationale

- ✓ Improvement of service delivery
- ✓ Reduction in service duplicatio
- ✓ Links amoung families and professionals for efficient service utilities

Northeast Regional Higher Education Institute, 1995

Collaborations Transparency #3

Conflict Management Styles

- ✓ Competitive
- ✓ Avoidance
- ✓ Accommodating
- ✓ Compromising
- ✓ Collaborative

Northeast Regional Higher Education Institute, 1995

Collaborations Transparency #4

Competitive Style: people who try to overpower the others with whom they have a conflict

- goal is "winning" regardless of negative repercussions
- others may stop interacting with you in a meaningful way
- can seriously damage/inhibit collaborative relationships

+ appropriate when ethical issues are at stake
+ when you are certain you are right

Northeast Regional Higher Education Institute, 1995

Collaborations Transparency #5

Avoidance Style: people who prefer to avoid conflict by ignoring the discrepancy between their own goals and those of others

- gives the appearance that all is well, but it is not
- conflict that is not resolved can continue to plague the group
- conflict can escalate from inaction

+ when conflict is emotionally laden, temporary avoidance allows involved individuals to regain control of their emotions

+ when there is not adequate time to constructively address the conflict

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Collaborations Transparency #6

Accommodating Style: people who put aside their own needs in order to ensure that others' needs are met

- may feel as though others are taking advantage of you
- you may have the right answer
- others may devalue your ideas if you accommodate too often

+ when conflict is relatively unimportant
+ brings conflict to a quick close
+ when you cannot alter the situation

Northeast Regional Higher Education Institute, 1995

Compromising Style: people who give up some on an issue while asking others to do the same

- doesn't meet the needs of all
- may feel dissatisfied if you are competitive by nature

+ is acceptable to all
+ useful when time is limited
+ when deadlocked in conflict over an issue

Northeast Regional Higher Education Institute, 1995

Collaborations Transparency #8

Collaborative Style: people who utilize a high degree of both assertiveness and cooperativesness

- time consuming
- requires professionals to learn about and trust one another

+ may develop new and creative alternatives to conflict

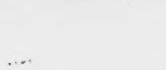
+ common commitment and clarity of issues results in less conflict and greater satisfaction

Northeast Regional Higher Education Institute, 1995

Collaborations Transparency #9

Barriers to Collaborations

- ✓ Competitiveness Between Agencies
- ✓ Lack of Organizational Structure for Coordination
- ✓ Technical Factors
- ✓ Personnel



Northeast Regional Higher Education Institute, 1995

Collaborations Transparency #10

Competitiveness Between Agencies

- ✓ Turf issues
- ✓ Lack of information about other agencies' functions
- ✓ Political issues

Northeast Regional Higher Education Institute, 1995

Collaborations Transparency #11

Lack of Organizational Structure for Coordination

- ✓ Differing philosophies
- ✓ Independent goals
- ✓ Haphazard team process
- ✓ Lack of facilitator
- ✓ Lack of monitoring and evaluation process
- ✓ Lack of planning
- ✓ Lack of power and authority to make and implement decisions

Northeast Regional Higher Education Institute, 1995

Technical Factors

- ✓ Resources: staff, time, budget
- ✓ Logistics: distance, geography

Collaborations Transparency #13

Personnel

- ✓ Parochial interests
- ✓ Resistance to change
- ✓ Staff attitudes
- ✓ Lack of commitment to community needs
- ✓ Questionable administrative support
- ✓ Discipline-specific jargon and perspectives

Collaborations Transparency #14

Steps for Resolving Conflict

- ✓ Clarify issues objectively
- ✓ Set expectations and outcomes
- ✓ Communicate clearly
- ✓ Use a variety of strategies
- ✓ Problem solving
- ✓ Brainnstorming
- ✓ Selecting from options
- ✓ Negotiation

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Negotiation Strategies

- ✓ Separate the people from the problem
- ✓ Focus on mutual interests
- ✓ Invent options and alternatives for mutual gain
- ✓ Manage anger and resistance
- ✓ Insist on using objective criteria
- ✓ Select options and alternatives

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Infants and Toddlers With Special Needs and Their Families

Collaborative Consultation

Northeast Regional Higher Education Institute, 1995

Instructional Module

Infants and Toddlers with Disabilities and Their Families:

Collaborative Consultation

PART ONE

I. Objectives
II. Outline
III. Explanatory Materials
IV. Evaluation
V. Resource Material

Instructional Module

Infants and Toddlers with Disabilities and Their Families: Collaborative Consultation

I. Objectives

Participants will:

1. Provide a rationale for consultation in early intervention
2. Define collaborative consultation
3. Describe principles of collaborative consultation
4. Describe strategies to use during collaborative consultation
5. Provide examples of collaborative consultation

II. OUTLINE

A. Rationale--Consultation can:

1. be used to resolve a needs, issue or problem.
2. improve the understanding that individuals have of issues and their ability to respond effectively to similar problems on the future.
3. decrease the number of service providers involved with the direct service delivery.

B. Definition: An interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems.

C. Principles

1. Mutual ownership of the process
2. Recognition of individual differences in the change process
3. Use of reinforcement principles and practices to improve skills, knowledge and attitudes
4. Use of data based decision making

D. Strategies

1. Treat others with respect
2. Share relevant information
3. Use appropriate language
4. Listen to others
5. Model the use of interview skills
6. Demonstrate a willingness to learn from others
7. Give and receive feedback

8. Give others credit for their ideas and accomplishments
9. Manage conflict and confrontation appropriately
10. Adapt situational leadership to Collaborative Consultation

E. Examples
   1. Therapy
   2. Childcare

F. Activity
   1. Evaluate system
   2. Evaluate work environment

III. Explanatory Material/Expansion of Module Outline

A. Rationale: Consultation Can: [Transparency 1]

A number of models for consultation have been used to provide services to children with disabilities (File & Kontos 1992). Generally speaking, consultation is the giving and taking of the information between two or more people to (1) resolve a need, issue, or problem; and (2) improve the understanding that one or both individuals have of these issues and their ability to respond effectively to similar problems in the future (Gutkin & Curtis 1982). One person may be involved with different consultations with different staff. What is most important, however, is the relationship between the two key individuals involved in the consultation. When the consultation involves providing services to a young child with a disability, the child becomes the third person involved.

Consultation can be used to provide two types of services to a child with a disability: direct and indirect (Idol 1993). The consultant can provide direct educational and related services, such as assessment of and instruction in a child's deficit area (Idol, Paolucci-Whitcomb, & Nevin 1986). The consultant can also provide assistance to teachers who have children with disabilities in their classrooms as well as to the parents of these children (Idol 1993). Within an early childhood program that includes children with disabilities, it seems clear that both consultant functions are necessary.

As stated, most of the empirical basis for using consultation has evolved from research on a school-age population of children with disabilities. Although this scope is limited, the studies confirm that consultation is an effective strategy for service delivery (Medway 1982; Medway & Updyke 1985; Sibley 1986; Gresham & Kendall 1987, West & Idol 1987; Kratochwill, Sheridan, & VanSomeren 1988; Bergan & Kratochwill 1990). In particular, consulting models of indirect service delivery in special education and related services has proven to be as effective as direct services provided in a pull-out (of the classroom) model when measures of children's achievement are compared (Miller & Sabatino 1978; Dunn 1990; Schulte, Osborne, & McKinney 1990). More important, however, teachers who called on consultants demonstrated positive changes in instructional techniques when using a consultant to meet a child's educational need (Meyers, Gelzheiser, & Yelich 1991). These outcomes have been replicated within early childhood settings (Peck, Killen, & Baugmart 1989; Dunn 1990; Hanline 1990).

B. Definition: [Transparency 2]

Related research on consultation strategies has focused on the methods used during the process of problem solving (Tindal, Shinn, & Rodden-Nord 1990). Evidence suggests that both special educators and general educators prefer a collaborative model (Wenger 1979; Babcock & Pryzwansky 1983; Pryzwansky & White 1983) rather than an expert model. The collaborative model, derived from Tharp and Werzel 1969, has been defined as

> an interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems. The major outcome of collaborative consultation is to provide comprehensive and effective programs for students with special needs within the most appropriate context, thereby enabling them to achieve maximum constructive interaction with their nonhandicapped peers. (Idol, Paolucci-Whitcomb, & Nevin 1986, p. 1)

Collaborative consultation encompasses a number of interpersonal competencies that cross discipline boundaries, including written and oral communication skills; personal characteristics, such as the ability to be caring, respectful, empathic, congruent and open; and collaborative problem solving skills (West & Cannon 1988). The last attribute, in particular, is crucial to the development of a relationship of parity between both (or all, if there are more than two) individuals involved in the consultation.

C. Principles: [Transparency 3]

A number of principles have been identified as contributing to the successful implementation of collaborative consultation among professionals from disciplines (Idol, Paolucci-Whitcomb, & Nevin 1986):

- *Mutual ownership of the process.* It is important that the participants in the consultation together identifying the need, issue, or problem. They should accept mutual responsibility or ownership of the consulting process and subsequent outcomes. Each person must respect, recognize, and appreciate the others' expertise.

- *Recognition of individual differences in the change process.* All parties should be aware of the change process and the developmental stages of concern for change that have been identified (Hall & Loucks 1978). It is important that both recognize that people embrace change differently, at different rates and at different emotional levels.

- *Use of reinforcement principles and practices to improve skills, knowledge, and attitudes.* When all of those involved in the consultation use effective teaching skills with each other and with the child with disabilities, positive outcomes accrue for all.

- *Use of data-based decision making.* The implementation of collaborative consultation strategies requires the adoption of a model of evaluation that measures the functional outcome of a child's behavior. The effects of each participant on the identified need, issue, or problem must be analyzed continuously to evaluate the effectiveness of the collaboration.

D. Strategies: [Transparency 4]

A number of strategies have been identified to assist in the collaborative consultation process. These strategies are crucial to the delivery of services. They will be described:

1. *Treat others with respect.* Collaborators need to treat each other with respect (Corey & Corey, 1992; West et al., 1989) This is important throughout the consultation process, but it is especially important in gaining entry and building team goals. Collaborators can model respect for other people by listening to them, by sharing information, by engaging in joint problem solving, by maintaining confidentiality, and by treating one another in a mannerly fashion. Collaborators must listen to descriptions about what kind of special assistance other team members think they want and need. Likewise, collaborators need to explain what they think their own special skills are so that, together, they can determine how they can best work together to provide educational services. It is especially important that collaborators show respect for each other by keeping team information confidential (Brill, 1990; Lippitt & Lippitt, 1986; Shulman, 1984). Collaborators should never discuss other members of the team unless they have specific permission to do so.

2. *Share relevant information.* Collaborators need to share information about their own skills in assessment, instruction, and evaluation so

they will be able to determine when and how to request one another's assistance (Friend & Cook, 1992; West et al., 1989). Brief, clear descriptions of assessment, instruction, and evaluation instruments and techniques will enable collaborators to gain some idea about how they might use each other's assistance (Idol, 1993; Lippitt & Lippitt, 1986; Montgomery, 1980; West et al., 1989).

3. *Use appropriate language.* Appropriate language increases the probability of shared meaning (Friend & Cook, 1992, Idol, 1993; Johnson, 1986; Verderber, 1981). Collaborators should be able to describe their program goals and special skills in a language that is familiar to other school personnel. Occasionally, it is appropriate for collaborators to use a new term because it is the most effective and accurate way of describing a behavior, procedure, or material. When that happens, it is important for the sender to explain the new term and the purpose for its use so that it can quickly become shared information and therefore a part of all of the team members' repertoire.

4. *Listen to others.* Collaborators can use appropriate listening skills in at least two ways: First, they can model passive listening by just keeping quiet and really listening to what others say. Second, they can use active listening by providing feedback on what they think others have said. This feed back process provides others with the opportunity either to confirm that they heard correctly or to correct any inaccuracy the interpretation of their original message (Conoley & Conoley, 1982; Gordon, 1980; Johnson, 1986, 1990; Montgomery 1980, Verderber, 1981. West et al. (1989, Module 14) have offered training opportunities on six specific appropriate listening and responding skills (acknowledging, paraphrasing, reflecting, clarifying, elaborating, and summarizing).

5. *Model the use of interview skills.* Collaborators need to use specific interviewing skills so that they can gain information from others, share information, express and explore their feelings about working together, solve problems, and plan appropriate future action on behalf of learners. The interview process provides an opportunity for collaborators to model purposeful and directed verbal interactions that can help to increase a shared information base and a willingness to work with others. Later, classroom teachers can use those same skills when working with learners in their own classrooms (Benjamin, 1987; Molyneaux & Lane, 1982; West et al., 1989).

6. *Demonstrate a willingness to learn from others.* Collaborators must demonstrate a willingness to learn from others if they want others to learn from them (Montgomery, 1980). Collaborative consultation is a problem-solving process in which the members have many chances to learn and teach one another. All members have specific, yet different, skills and knowledge to share. Some collaborators have knowledge about special education assessment and intervention techniques, while others have specific knowledge about curriculum, child development, content area specifics, and so on. Thus, collaborative consultation team members have different but equally valued knowledge and skills that need to be s hared for the benefit of all learners (Gordon, 1980; Lippitt & Lippitt, 1986).

7. *Give and receive feedback.* Giving and receiving feedback is of vital importance to the chance process (Conoley & Conoley, 1982; Friend & Cook, 1992; Heresy & Blanchard, 1988; Idol, 1993; Johnson, 1986; Verderber, 1981; West et al., 1989, Module 21): It is often helpful to identify at least two areas that deserve positive feedback; one area that needs improvement, and then one or two areas of strength. Feedback should be specific, immediate, and appropriate. Collaborators should engage in both giving and receiving feedback. One strategy for doing this is to say, "I think I did those two things very well, but it seems as if I need to improve here. However, it does make me feel good to know that identifying and adapting intervention techniques are two of my major strengths. How do you think I could improve those two techniques?" This situation provides an opportunity for collaborators to model both the process of self-evaluation and the process of requesting feedback. Collaborators also model the technique of requesting a perception check by obtaining their team members' view of their own skills. Collaborators can give feedback by responding to others' views of their own strengths and areas in need of improvement. A major concept that is built through this process is that the focus of change is on behaviors, not people. There are no good or bad people or techniques but rather areas of strength or effectiveness and areas that need improvement. Patience, mutual respect, and shared skills can, however, make the process of giving and receiving feedback easier and more enjoyable.

8. *Give others credit for their ideas and accomplishments.* Collaborative consultation is a shared process of responsibilities and rewards (West et al., 1989, Module 22). Collaborators can model the practice of

giving others credit for their ideas and accomplishments. That includes providing credit for ideas in written materials, as well. This practice increases the probability that collaborators will share their knowledge and rewards, thus providing increased strength and willingness to identify and solve more problems.

9. *Manage conflict and confrontation appropriately.* Conflicts or disagreements are inevitable in human relationships. The goal is for collaborators to model the appropriate use of confrontation skills so that a no-lose method of resolving conflict is utilized. When appropriate confrontation skills are used, both parties express their points of view and listen to each other. They use "I" messages to express their needs, feelings, and concerns, instead of blaming the other person for their conflicts. Finally, they search together for creative and mutually acceptable solutions (Friend & Cook, 1992, Gordon, 1980; Johnson, 1986, 1990, West et al., 1989, Module 23).

10. *Adapt situational leadership to Collaborative consultation.* Collaborators need to determine the attitude and skill levels of the people they will be collaborating with, so that they can adjust their collaboration styles to match the maturity level of each member of the group. Maturity levels should be identified by determining each member's willingness, as well as skills, and knowledge to provide special or remedial services. The amount of special education coursework the collaborator has completed and the number of years the collaborator provided effective services are two possible indicators of their willingness and ability to work with learners with special needs. The concept of situational collaboration has been adapted from situational leadership, which was described by Hersey and Blanchard (1988) and Toseland and Rivas (1984).

Consultation appears likely to become an increasingly prominent method of service delivery for early childhood special educators and related- service personnel (File & Kontos 1992). Many program models that include children with disabilities in community early childhood programs have supported this model (Bagnato, 1988; Bruder 1993). However, the strategy of collaborative consultation for service delivery by professionals from different disciplines cannot be advocated without noting the barriers. Staff from different agencies who often have different philosophies of service, financial resources, and time constraints, may not understand and respect one another's professional frameworks and skills

(Johnson, Pugach, & Hammitte 1988; Johnson Pugach 1991). Sometimes staff from one agency or discipline perceive themselves to be more highly skilled than are staff from the other discipline (Carter 1989; Pugach & Johnson 1989). This often can happen in the context of a collaboration between an early childhood teacher and a special educator; the teacher may be less skilled than the special educator in intervention, although she is more skilled in many other aspects of working with young children. All staff involved need to acknowledge such existing barriers before beginning the collaboration. All staff involved must demonstrate mutual respect for each other because each professional will benefit from the others' expertise. This is the very core of a collaborative consultation relationship.

E. Example:

How could the collaborative consultation model be used in the following case historues:

1. Therapy: [Handout 1]

Child: Kara (age 4 years)

Other Children: None

Parent(s) Maya (mother age 24)

John (father age 23)

Possible solution for implementing the collaborative consultation model of service delivery:

> Before asking for Kara's removal from the Head Start program, the program director requested a meeting between the classroom teacher, the speech pathologist, the psychologist, and Kara's parents. At the meeting the group decided to try one more strategy to try to help Kara's behavior. The speech pathologist agreed to redistribute her time with Kara, although she expressed uncertainty about the chances of Kara learning better communication and language skills outside a distraction-free therapy environment. She began to spend time with Kara in the classroom twice a week and used her third day to meet with the teacher during lunchtime to help identify approaches the teacher could use to help Kara communicate

her needs more effectively. The psychologist also agreed to come to the classroom twice a week to record the times when Kara's problematic behavior seemed be worse. He met with the teacher and parents weekly to identify the events that led to the behavior episodes and the strategies that seemed to help Kara. He also demonstrated to both Kara's teacher and her parents techniques that seemed to be effective with Kara. For example, Kara was given a sticker chart, which was used by the teacher every time Kara appropriately communicated her needs. She was also given more verbal cues to prepare her for transitions, a particularly difficult time for her. After six weeks of consultation, Kara's behavior showed a big improvement, and the psychologist reduced his time investment to twice-a-month visits with the teacher. Kara's speech and language has improved, and the speech pathologist has learned to provide services within Kara's classroom activities, in group situations. The teacher also feels much more comfortable and effective in meeting Kara's needs.

2. Childcare: [Handout 2]

Child: Joley (age 4 years)

Other Children: None

Parent(s) Mary (mother)

Possible solution for implementing the collaborative consultation model of service delivery:

Joley's mother agreed with the child care staff to request a meeting with the staff at the special education center. At the meeting she asked if there was any way the special education staff could help the child care staff. The members of the special education staff agreed to consult with the child care staff on a weekly basis to help them teach intervention techniques to use with Joley to address all of her developmental needs. The process was hard in the beginning because schedules were difficult to coordinate. Before long, however, members from both programs felt comfortable with each other and began to jointly help each other problem solve to meet Joley's needs. After four months of this regular communication and teaching and learning from each other, the special education staff believed that they should stop taking Joley out of her natural environment every day because the child care staff was doing such a good job incorporating her individualized interventions and adaptations into their classroom routines. Certain members of the special education team increased their visits to see Joley at the child care center to make up for their lack of daily contact, and evaluations of her progress suggested that this change in intervention benefited her enormously.

F. Activities:

Use the following evaluation tools to perform self checks

1. Evaluate the system [Handout 3]

Evaluation of system for monitoring collaborator acquisition and practice of generic principles of collaborative consultation.

	Never		**So-So**		**Often**
I feel team ownership of the identified problem.	1	2	3	4	5
I recognize and respect individual differences.	1	2	3	4	5
I use situational leadership.	1	2	3	4	5
I use cooperative conflict-resolution processes.	1	2	3	4	5
I use appropriate interviewing skills.	1	2	3	4	5
I actively listen to others.	1	2	3	4	5
I communicate using common nonjargon and positive nonverbal language.	1	2	3	4	5

2. **Evaluate the work environment [Handout 4]**

Collaborative work environment self-assessment.

Instructions: The norms for staff behavior listed below are those frequently found in collaborative work environments in schools. Please read each statement carefully. Then rate the degree to which each statement reflects the current work environment in your school, with 1 = our staff always behaves this way; 2 = our staff behaves this way most of the time; 3 = our staff behaves this way sometimes; 4 = our staff behaves this way rarely; or 5 = our staff never behaves this way.

__________ 1. The staff shares a common language about instructional techniques.

__________ 2. The staff often observes each other in their classrooms and give feedback on instruction.

__________ 3. The staff frequently discusses instructional techniques and methods in the workroom/lounge.

__________ 4. The staff works together to master new instructional methods or strategies.

__________ 5. The staff plans and designs educational materials together.

__________ 6. The staff pools their expertise and shares their resources with each other.

__________ 7. The staff learns from and with each other.

__________ 8. Time is specifically devoted at staff meetings to demonstrate and discuss innovative educational techniques, materials, or strategies.

__________ 9. Discussion in the staff lounge/workroom centers mostly on instructional practices rather than on social concerns or complaints about learners.

__________ 10. Time is specifically provided for professional staff to plan and problem-solve together.

IV. Evaluation

The case histories may be used, also, as evaluation tools by asking one or more of the following questions:

1. How could the collaborative consultation model be used to improve services for this child.

2. Why should the collaborative consultation model be used in early intervention? Use facts from the case history to support your rationale.

Handout #1

Child: Kara (age 4 years)

Other Children: None

Parent(s) Maya (mother age 24)

John (father age 23)

Kara attends a Head Start Program five mornings a week. In October Kara was referred to the special needs coordinator of the local Head Start program because of her behavior problems. Her parents agreed to have her tested by the local school district special education team. The special education team determined that Kara was not eligible for their preschool services but that she could receive speech and language services because of articulation problems. The speech pathologist from the school district began to see Kara three mornings a week in a small room set aside for speech therapy at the Head Start program. The Head Start teacher did not know what went on in the speech room but hoped it was helping Kara's speech. Unfortunately, though, Kara's behavior in class kept getting worse, so that the Head Start director asked the local mental health center to send a psychologist to the classroom to observe Kara. The psychologist asked the classroom teacher to provide a lot of data and suggested that she change her style of teaching. The teacher tried at first, but Kara's behavior did not improve, and the whole classroom routine was disrupted. The psychologist said that he could come to the classroom two hours a week to implement a behavior modification program, but he did not know if it would help. The Head Start staff (especially the teacher) now feel that Kara should be removed from Head Start and sent to a special education school because neither of the specialists have been able to help her. If the special education school will not take her, she will just have to stay at home.

Handout #2

Child: Joley (age 4 years)

Other Children: None

Parent(s) Mary (mother)

Joley is 4 years old and has Down Syndrome. She has two younger brothers. Her mom, Mary, is single and works two jobs. Joley attends the Busy Bee Child Care Center for a total of seven hours a day. Her mom drops her off at 7:30 for breakfast. Joley spends the rest of the morning at the child care center. She is picked up by a bus at 11:30 to go to a preschool special education center (40 minutes away), where she attends a class every afternoon and receives special education and related services that include speech, occupational, and physical therapy. She returns to the child care center every day at 3:00 p.m. and stays until 6:00 p.m., when her grandmother picks her up. Joley does very well at the child care program, but the teachers think they should be doing more with her. They wish they knew what happened during the special education class and what all the special staff did to her. They also worry about all the transitions Joley has to make in one day. Joley's mother has also expressed concern about all the traveling her daughter has to do between the two programs.

Handout #3

Evaluation of system for monitoring collaborator acquisition and practice of generic principles of collaborative consultation.

Collaborator: ________________________ **Date:** ____________

	Never		So-So		Often
I feel team ownership of the identified problem.	1	2	3	4	5
I recognize and respect individual differences.	1	2	3	4	5
I use situational leadership.	1	2	3	4	5
I use cooperative conflict-resolution processes.	1	2	3	4	5
I use appropriate interviewing skills.	1	2	3	4	5
I actively listen to others.	1	2	3	4	5
I communicate using common nonjargon and positive nonverbal language.	1	2	3	4	5

Handout #4

Collaborative work environment self-assessment.

Name:____________________ **Postion:**_____________ **School/Unit**____________

Instructions: The norms for staff behavior listed below are those frequently found in collaborative work environments in schools. Please read each statement carefully. Then rate the degree to which each statement reflects the current work environment in your school, with 1 = our staff always behaves this way; 2 = our staff behaves this way most of the time; 3 = our staff behaves this way sometimes; 4 = our staff behaves this way rarely; or 5 = our staff never behaves this way.

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___ 5. The staff plans and designs educational materials together.

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___ 7. The staff learns from and with each other.

___ 8. Time is specifically devoted at staff meetings to demonstrate and discuss innovative educational techniques, materials, or strategies.

___ 9. Discussion in the staff lounge/workroom centers mostly on instructional practices rather than on social concerns or complaints about learners.

___ 10. Time is specifically provided for professional staff to plan and problem-solve together.

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Instructional Module

Infants and Toddlers with Disabilities and Their Families:

Collaborative Consultation

PART TWO

Supporting Materials

I. Lecture Notes
II. Student Handouts for Note-Taking
III. Additional Student Handouts
IV. Transparency Samples

Handout #1

Child: Kara (age 4 years)

Other Children: None

Parent(s) Maya (mother age 24)

John (father age 23)

Kara attends a Head Start Program five mornings a week. In October Kara was referred to the special needs coordinator of the local Head Start program because of her behavior problems. Her parents agreed to have her tested by the local school district special education team. The special education team determined that Kara was not eligible for their preschool services but that she could receive speech and language services because of articulation problems. The speech pathologist from the school district began to see Kara three mornings a week in a small room set aside for speech therapy at the Head Start program. The Head Start teacher did not know what went on in the speech room but hoped it was helping Kara's speech. Unfortunately, though, Kara's behavior in class kept getting worse, so that the Head Start director asked the local mental health center to send a psychologist to the classroom to observe Kara. The psychologist asked the classroom teacher to provide a lot of data and suggested that she change her style of teaching. The teacher tried at first, but Kara's behavior did not improve, and the whole classroom routine was disrupted. The psychologist said that he could come to the classroom two hours a week to implement a behavior modification program, but he did not know if it would help. The Head Start staff (especially the teacher) now feel that Kara should be removed from Head Start and sent to a special education school because neither of the specialists have been able to help her. If the special education school will not take her, she will just have to stay at home.

Handout #2

Child: Joley (age 4 years)

Other Children: None

Parent(s) Mary (mother)

Joley is 4 years old and has Down Syndrome. She has two younger brothers. Her mom, Mary, is single and works two jobs. Joley attends the Busy Bee Child Care Center for a total of seven hours a day. Her mom drops her off at 7:30 for breakfast. Joley spends the rest of the morning at the child care center. She is picked up by a bus at 11:30 to go to a preschool special education center (40 minutes away), where she attends a class every afternoon and receives special education and related services that include speech, occupational, and physical therapy. She returns to the child care center every day at 3:00 p.m. and stays until 6:00 p.m., when her grandmother picks her up. Joley does very well at the child care program, but the teachers think they should be doing more with her. They wish they knew what happened during the special education class and what all the special staff did to her. They also worry about all the transitions Joley has to make in one day. Joley's mother has also expressed concern about all the traveling her daughter has to do between the two programs.

Handout #3

Evaluation of system for monitoring collaborator acquisition and practice of generic principles of collaborative consultation.

Collaborator: ______________________________ **Date:** ______________

	Never		So-So		Often
I feel team ownership of the identified problem.	1	2	3	4	5
I recognize and respect individual differences.	1	2	3	4	5
I use situational leadership.	1	2	3	4	5
I use cooperative conflict-resolution processes.	1	2	3	4	5
I use appropriate interviewing skills.	1	2	3	4	5
I actively listen to others.	1	2	3	4	5
I communicate using common nonjargon and positive nonverbal language.	1	2	3	4	5

Handout #4

Collaborative work environment self-assessment.

Name:____________________ **Postion:**______________ **School/Unit**____________

Instructions: The norms for staff behavior listed below are those frequently found in collaborative work environments in schools. Please read each statement carefully. Then rate the degree to which each statement reflects the current work environment in your school, with 1 = our staff always behaves this way; 2 = our staff behaves this way most of the time; 3 = our staff behaves this way sometimes; 4 = our staff behaves this way rarely; or 5 = our staff never behaves this way.

___ 1. The staff shares a common language about instructional techniques.

___ 2. The staff often observes each other in their classrooms and give feedback on instruction.

___ 3. The staff frequently discusses instructional techniques and methods in the workroom/lounge.

___ 4. The staff works together to master new instructional methods or strategies.

___ 5. The staff plans and designs educational materials together.

___ 6. The staff pools their expertise and shares their resources with each other.

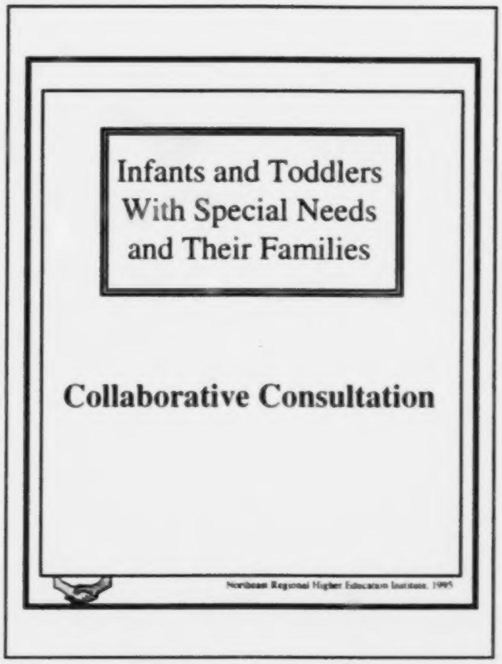
___ 7. The staff learns from and with each other.

___ 8. Time is specifically devoted at staff meetings to demonstrate and discuss innovative educational techniques, materials, or strategies.

___ 9. Discussion in the staff lounge/workroom centers mostly on instructional practices rather than on social concerns or complaints about learners.

___ 10. Time is specifically provided for professional staff to plan and problem-solve together.

Faculty Presentation Guide



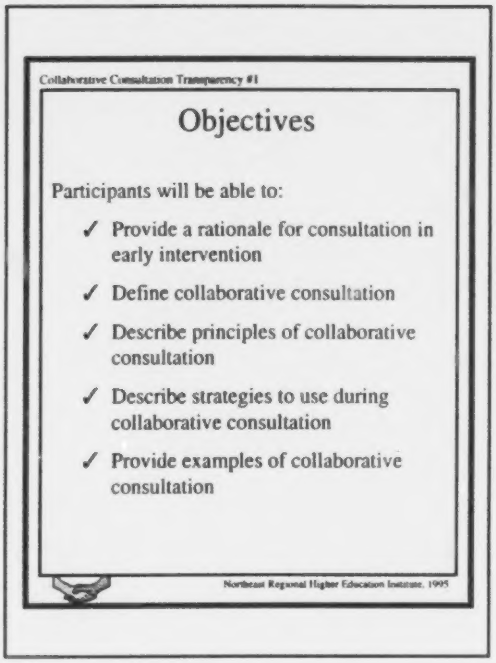
Infants and Toddlers
With Special Needs
and Their Families

Collaborative Consultation

Lecture Notes

Northeast Regional Higher Education Institute, 1995

Faculty Presentation Guide



Collaborative Consultation Transparency #1

Objectives

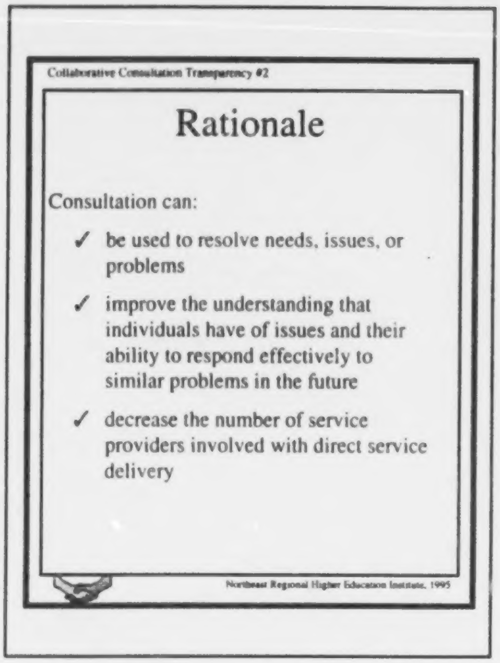
Participants will be able to:

- ✓ Provide a rationale for consultation in early intervention
- ✓ Define collaborative consultation
- ✓ Describe principles of collaborative consultation
- ✓ Describe strategies to use during collaborative consultation
- ✓ Provide examples of collaborative consultation

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Faculty Presentation Guide



Collaborative Consultation Transparency #2

Rationale

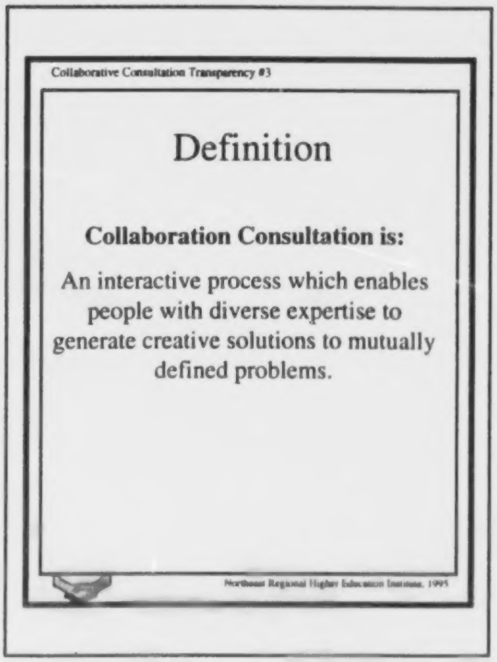
Consultation can:

- ✓ be used to resolve needs, issues, or problems
- ✓ improve the understanding that individuals have of issues and their ability to respond effectively to similar problems in the future
- ✓ decrease the number of service providers involved with direct service delivery

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Faculty Presentation Guide



Collaborative Consultation Transparency #3

Definition

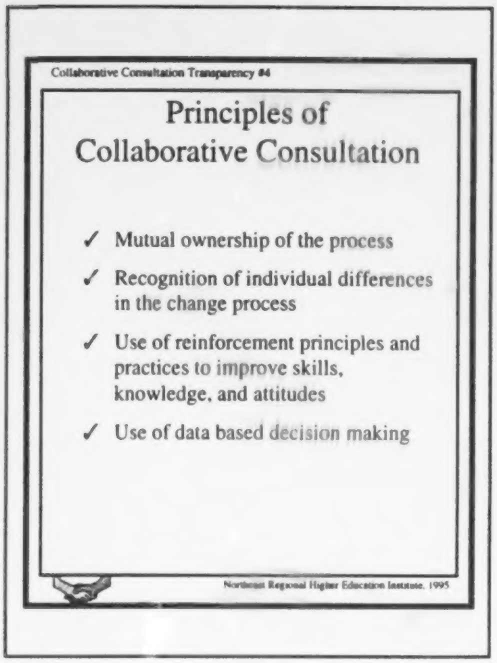
Collaboration Consultation is:

An interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems.

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Faculty Presentation Guide



Collaborative Consultation Transparency #4

Principles of Collaborative Consultation

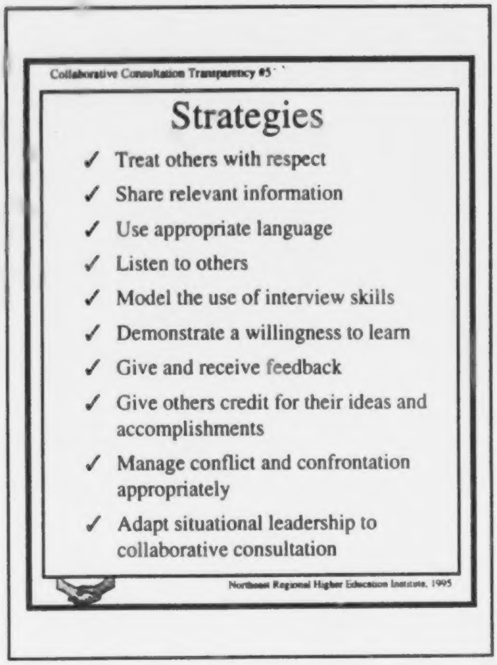
- ✓ Mutual ownership of the process
- ✓ Recognition of individual differences in the change process
- ✓ Use of reinforcement principles and practices to improve skills, knowledge, and attitudes
- ✓ Use of data based decision making

Northeast Regional Higher Education Institute, 1995

Lecture Notes

Northeast Regional Higher Education Institute, 1995

Faculty Presentation Guide



Collaborative Consultation Transparency #5

Strategies

✓ Treat others with respect
✓ Share relevant information
✓ Use appropriate language
✓ Listen to others
✓ Model the use of interview skills
✓ Demonstrate a willingness to learn
✓ Give and receive feedback
✓ Give others credit for their ideas and accomplishments
✓ Manage conflict and confrontation appropriately
✓ Adapt situational leadership to collaborative consultation

Northeast Regional Higher Education Institute, 1995

Lecture Notes

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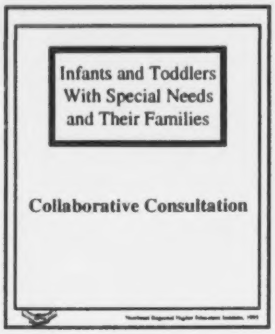
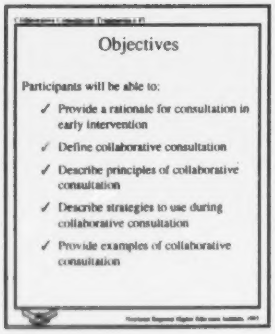
Student Handouts- Collaborative Consultation



Infants and Toddlers
With Special Needs
and Their Families

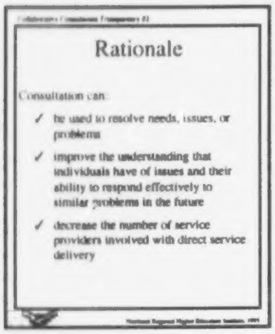
Collaborative Consultation



Objectives

Participants will be able to:

- ✓ Provide a rationale for consultation in early intervention
- ✓ Define collaborative consultation
- ✓ Describe principles of collaborative consultation
- ✓ Describe strategies to use during collaborative consultation
- ✓ Provide examples of collaborative consultation



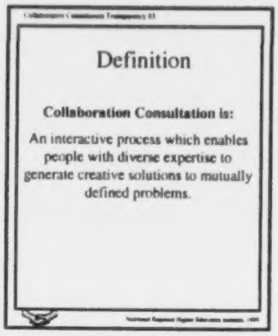
Rationale

Consultation can:

- ✓ be used to resolve needs, issues, or problems
- ✓ improve the understanding that individuals have of issues and their ability to respond effectively to similar problems in the future
- ✓ decrease the number of service providers involved with direct service delivery

Student Handouts- Collaborative Consultation

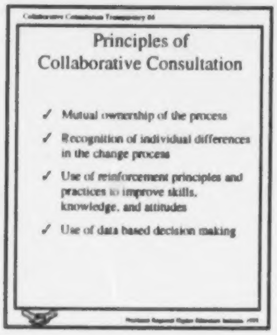
Page # 2



Definition

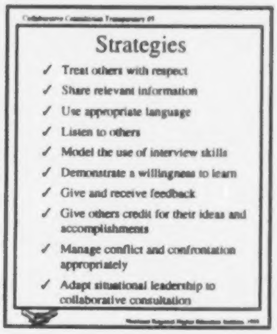
Collaboration Consultation is:

An interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems.



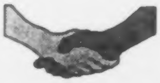
Principles of Collaborative Consultation

- ✓ Mutual ownership of the process
- ✓ Recognition of individual differences in the change process
- ✓ Use of reinforcement principles and practices to improve skills, knowledge, and attitudes
- ✓ Use of data based decision making



Strategies

- ✓ Treat others with respect
- ✓ Share relevant information
- ✓ Use appropriate language
- ✓ Listen to others
- ✓ Model the use of interview skills
- ✓ Demonstrate a willingness to learn
- ✓ Give and receive feedback
- ✓ Give others credit for their ideas and accomplishments
- ✓ Manage conflict and confrontation appropriately
- ✓ Adapt situational leadership to collaborative consultation



Infants and Toddlers With Special Needs and Their Families

Collaborative Consultation

Northeast Regional Higher Education Institute, 1995

Handout #1

Child: Kara (age 4 years)

Other Children: None

Parent(s) Maya (mother age 24)

John (father age 23)

Kara attends a Head Start Program five mornings a week. In October Kara was referred to the special needs coordinator of the local Head Start program because of her behavior problems. Her parents agreed to have her tested by the local school district special education team. The special education team determined that Kara was not eligible for their preschool services but that she could receive speech and language services because of articulation problems. The speech pathologist from the school district began to see Kara three mornings a week in a small room set aside for speech therapy at the Head Start program. The Head Start teacher did not know what went on in the speech room but hoped it was helping Kara's speech. Unfortunately, though, Kara's behavior in class kept getting worse, so that the Head Start director asked the local mental health center to send a psychologist to the classroom to observe Kara. The psychologist asked the classroom teacher to provide a lot of data and suggested that she change her style of teaching. The teacher tried at first, but Kara's behavior did not improve, and the whole classroom routine was disrupted. The psychologist said that he could come to the classroom two hours a week to implement a behavior modification program, but he did not know if it would help. The Head Start staff (especially the teacher) now feel that Kara should be removed from Head Start and sent to a special education school because neither of the specialists have been able to help her. If the special education school will not take her, she will just have to stay at home.

Handout #2

Child: Joley (age 4 years)

Other Children: None

Parent(s) Mary (mother)

Joley is 4 years old and has Down Syndrome. She has two younger brothers. Her mom, Mary, is single and works two jobs. Joley attends the Busy Bee Child Care Center for a total of seven hours a day. Her mom drops her off at 7:30 for breakfast. Joley spends the rest of the morning at the child care center. She is picked up by a bus at 11:30 to go to a preschool special education center (40 minutes away), where she attends a class every afternoon and receives special education and related services that include speech, occupational, and physical therapy. She returns to the child care center every day at 3:00 p.m. and stays until 6:00 p.m., when her grandmother picks her up. Joley does very well at the child care program, but the teachers think they should be doing more with her. They wish they knew what happened during the special education class and what all the special staff did to her. They also worry about all the transitions Joley has to make in one day. Joley's mother has also expressed concern about all the traveling her daughter has to do between the two programs.

Collaborative Consultation Transparency #1

Objectives

Participants will be able to:

- ✓ Provide a rationale for consultation in early intervention
- ✓ Define collaborative consultation
- ✓ Describe principles of collaborative consultation
- ✓ Describe strategies to use during collaborative consultation
- ✓ Provide examples of collaborative consultation

Northeast Regional Higher Education Institute, 1995

Rationale

Consultation can:

- ✓ be used to resolve needs, issues, or problems
- ✓ improve the understanding that individuals have of issues and their ability to respond effectively to similar problems in the future
- ✓ decrease the number of service providers involved with direct service delivery

Collaborative Consultation Transparency #3

Definition

Collaboration Consultation is:

An interactive process which enables people with diverse expertise to generate creative solutions to mutually defined problems.

Northeast Regional Higher Education Institute, 1995

Collaborative Consultation Transparency #4

Principles of Collaborative Consultation

- ✓ Mutual ownership of the process
- ✓ Recognition of individual differences in the change process
- ✓ Use of reinforcement principles and practices to improve skills, knowledge, and attitudes
- ✓ Use of data based decision making

Northeast Regional Higher Education Institute, 1995

Collaborative Consultation Transparency #5

Strategies

- ✓ Treat others with respect
- ✓ Share relevant information
- ✓ Use appropriate language
- ✓ Listen to others
- ✓ Model the use of interview skills
- ✓ Demonstrate a willingness to learn
- ✓ Give and receive feedback
- ✓ Give others credit for their ideas and accomplishments
- ✓ Manage conflict and confrontation appropriately
- ✓ Adapt situational leadership to collaborative consultation

Northeast Regional Higher Education Institute, 1995

APPENDIX D

Participant Information Interagency Institute I

ID	Position or Title	Place Of Employment	Service Provided	Highest Degree Earned	Formal Traing Y/N	Years working with Children	
						B-3	3-5
1	Regional Director	Northcentral Regional Family Service Coordination Center	Early Childhood Education and Early Childhood Special Education Administration	M.Ed	Y	20	6
2	Regional Director	Northwest Regional Family Service Coordination Center	Early Childhood Education and Early Childhood Special Education Administration		Y		
3	Regional Director	Southeast Regional Family Service Coordination Center	Early Childhood Education and Early Childhood Special Education Administration	M.Ed	Y	30	0
4	Regional Director	Southwest Regional Family Service Coordination Center	Early Childhood Education and Early Childhood Special Education Administration	MS-SLP	Y	11	2
5	Regional Director	Southcentral Regional Family Service Coordination Center	Early Childhood Education and Early Childhood Special Education Administration	MSW	Y	8	7

Participant Information Interagency Institute II

ID	Role	Age Of Child	Service Region	Job Title	Place Of Employment	Area Of Service Provided	Highest Degree
7	Provider						
8	Parent	21	3				
9	Provider						
10	Provider			Case Manager	New Haven Rehabilitation Center	Early Childhood Education Administration	BS
11	Parent	36	6				
12	Parent	99					
13	Parent	29	3				
14	Provider			Director Of Family Center	Newington Children's Hospital	Family Advocate	BA
15	Provider			Special Education Teacher	DMR Region 2	Early Childhood Special Education Teacher Early Childhood Special Education Consultant	MS
16	Provider			Director	Northcentral Region Family Service Coordination Center/CREC	Early Childhood Special Education Administration	MEd
17	Parent	30	1				
18	Provider						
19	Provider			Coordinator	B-3 Infoline	Administration	BS
20	Parent	36	2				
21	Provider			Regional Director	Rescue	Early Childhood Special Education Administration	MSW
22	Provider			Project Coordinator Ninos	DMR Region 4	Social Work	MSW
23	Provider			Director Of Pediatric Rehabilitation Center	Farfield County	Early Childhood Special Education Administration	6TH YEAR
24	Provider			Family Advocate	Department Of Public Health	Family Advocacy	BA

Institute II Participant Information Continued

ID	Role	Age Of Child	Service Region	Job Title	Place Of Employment	Area Of Service Provided	Highest Degree
25	Provider			Ass	Superinten DMR	Early Childhood Special Education Administration	6TH YEAR
26	Provider			Supt	Of School DMR	Early Childhood Special Education Administration	MS
27	Provider			Part H Coordinator	CT Department Of Education	Early Childhood Special Education Administration	EdD
28	Parent	27	3				
29	Provider			Coordinator	McCall Foundation		MS
30	Provider			Regional Family Service Coordination Center Director	Learn	Early Childhood Special Education Administration	Ph D
31	Provider			Sup	South Central Early Connections	Early Childhood Special Education Administration	6TH YEAR
32	Provider			St School Teach	DMR Region 1	Early Childhood Special Education Teacher	6TH YEAR
33	Provider			Service Director	Key Service Systems	Early Childhood Special Education Administration Early Childhood Special Education Teacher	MA
34	Provider			Director	Bridgeport Hospital	Pediatrician	MD
35	Provider			Health Program Assistant	CT Department Of Social Services	Medical	
36	Provider			Coordinator	Bridgeport Chhild Advocacy Coalition		MA
37	Both	37		Parent Advocate	The Family Center	Newington Children's Hospital	BS
38	Parent	36	2				

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Institute II Participant Information Continued

ID	Role	Age Of Child	Service Region	Job Title	Place Of Employment	Area Of Service Provided	Highest Degree
39	Parent	37					
40	Provider			Education Coordinator B-3	The Wheeler Clinic	Early Childhood Special Education Administration	MEd
41	Provider			Principal	DMR Early Connections	Early Childhood Special Education Administration	Ph D
42	Provider			Supervisor	DMR Region 1	Early Childhood Special Education Administration	6TH YEAR
43	Provider			Supervisor Early Childhood	DMR Early Connections	Early Childhood Special Education Administration	6TH YEAR
44	Provider			Director	Southwest Regional Family Service Coordination Center	Early Childhood Special Education Administration	MS
45	Provider			Director Of Ser Department	Of Mental Retardation	Early Childhood Special Education Administration	6TH YEAR
46	Provider			Director	ARC Greenwich	Early Childhood Special Education Administration	6TH YEAR
47	Both	37					
48	Parent	37					
49	Provider			Superintendant Of Special Education	Seymour Board Of Education	Early Childhood Special Education Administration	6TH YEAR
50	Parent	36	4				
51	Parent	42	1				
52	Provider			Reimbursement	DMR Central Office	Early Childhood Special Education Administration	PhD

Institute II Participant Information Continued

ID	Role	Age Of Child	Service Region	Job Title	Place Of Employment	Area Of Service Provided	Highest Degree
53	Provider			Director	Rehabilitation Associates	Early Childhood Special Education Administration	MS
54	Provider			Supervisor	DMR	Early Childhood Special Education Administration	6TH YEAR
55	Parent	60	2				
56	Provider			Service Coordinator	Southeast Region Family Service Coordination Center	Service Coordination	BS
57	Provider			Supervisor Early Intervention	American School For The Deaf	Early Childhood Special Education Administration	MA
58	Provider			Supervisor	DMR-Early Connections	Early Childhood Special Education Administration	6TH YEAR
59	Provider			Regional Director	Regional Family Service Coordiation Center -ACES	Early Childhood Special Education Administration	MSW
60	Provider			Execuative Director	United Cerebral Palsy		
61	Both			Student	Central Connecticut State University	Early Childhood Special Education Teacher	High School
62	Provider			Neonatalist	Complete Newborn Care	Medical Doctor	MD
63	Provider			Servicec Coordination	Northcentral Region Family Service Coordination Center	Service Coordination	BA
64	Provider						
65	Provider			B-3 Manager	CT Children's Medical Center	Administration	MA
66	Provider			Service Manager	Kennedy Center	Early Childhood Special Education Administration	BS

Institute II Participant Information Continued

ID	Role	Age Of Child	Service Region	Job Title	Place Of Employment	Area Of Service Provided	Highest Degree
67	Provider			Regional Manager	United Way Of CT INFOLINE	Other Area	MSW
68	Provider			MCH Coordinator	Infoline	Administration	RN
69	Provider			MCH Coordinator	Infoline	Administration	
70	Provider			Director B-3	Learn		
71	Provider			Supervisor	American School For The Deaf	Early Childhood Special Education Adminitration	MEd
72	Provider			619coordinator	State Department Of Education	Early Childhood Special Education Administration	MS
73	Provider			Southwest B-3			
74	Provider			Consultation Center			
75	Provider			Teacher	Hill Health Center/E. S. P.	Early Childhood Education Teacher	BS
76	Provider			Teacher	Clinicn The Hill Health Center	Early Childhood Education	BS
77	Provider			Parent Coordinator	Early Stimulation Program	Administration	BS
78	Provider			Early Childhood special Educator	Early Connections NC Region	Early Childhood Special Education Teacher	6TH YEAR
79	Provider			Nutritian Consultant	Department Of Public Health-Nutrition Unit	Consultations	MS
80	Provider			Co.-Director-PT	Reachout, Inc	Physical Therapy	MS
81	Parent	30	1				
82	Provider			B-3 Service Coordinator		Service Coordination	
83	Provider			Coordinator, Early Intervention Program	Datahr Rehab Institute	Physical Therapy	BS
84	Parent	18	4				

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Institute II Participant Information Continued

ID	Role	Age Of Child	Service Region	Job Title	Place Of Employment	Area Of Service Provided	Highest Degree
85	Provider			Director Early Connections Program	The Consultation Center	Administration	MS
86	Provider			Owner/Pt	Children's Therapy Services	Administration	MS
87	Provider			Director Of Health	Department Of Haelthof Health	Adinistration	
88	Provider			Parent Educator	Manchester Memorial Hospital	Advocacy	MSW
89	Provider			Manchester Mememorial Hospital	Family Support Center		
90	Parent	22					
91	Both						
94	Parent	19					
95	Provider						
96	Provider			Co.-Director	REACHOUT, Inc	Social Work	MSW
97	Provider			Director	Hill Health Center-Child Guidance	Administration	Post Masters
98	Provider			E. S. P. Head Teacher	Hill Health Center-Early Stimulation Program	Early Childhood Special Education Administration Early Childhood Special Education Teacher	MS
99	Provider			Coordinator Social Services	Datahr Rehabilitation Institute	Social Work	Post Masters
100	Provider			Assistant Director	CREC Hearing Impaired Program	Punt	MA
101	Provider			Assistant	Jane Bisantz & Assoc	Htfd Public School Speech & Language	Post Masters
102	Both			Co-Director	Project Interact	Social Work	MSW

Institute II Participant Information Continued

ID	Role	Age Of Child	Service Region	Job Title	Place Of Employment	Area Of Service Provided	Highest Degree
103	Provider			President/CEO	Morton Speech-Language Clinic	Early Childhood Education Administration Early Childhood Special Education Administration	CCC-SLP
104	Provider			RN, Assistant Director	Naugatuck Valley Health District	Nursing	RN
105	Provider			Program Manager	Camp Horizons	Early Childhood Special Education Consultant	BS
106	Provider			Director Of Rehabilitation Services	OMNI Inc	Early Childhood Special Education Administration	MA
107	Provider			Executive Director	Sarah Inc	Administration	
108	Provider			Nurse Consultant	Department Of Public Health/MCH	Consultations	RN
109	Provider			Director Of Consultant Services	DMR		MS
110	Provider			Vice President	Easter Seal/New Haven	Early Childhood Education Administration Early Childhood Special Education Administration	
111	Provider			Speach/Language Pathologist	Joe Mclaughlin-Private Practice	Speech & Language	CCC-SLP
112	Provider						
113	Provider			Evaluator	Southwest Regional Family Service Coordination Center	Early Childhood Special Education Administration Occupational Therapy	6TH YEAR
114	Provider						

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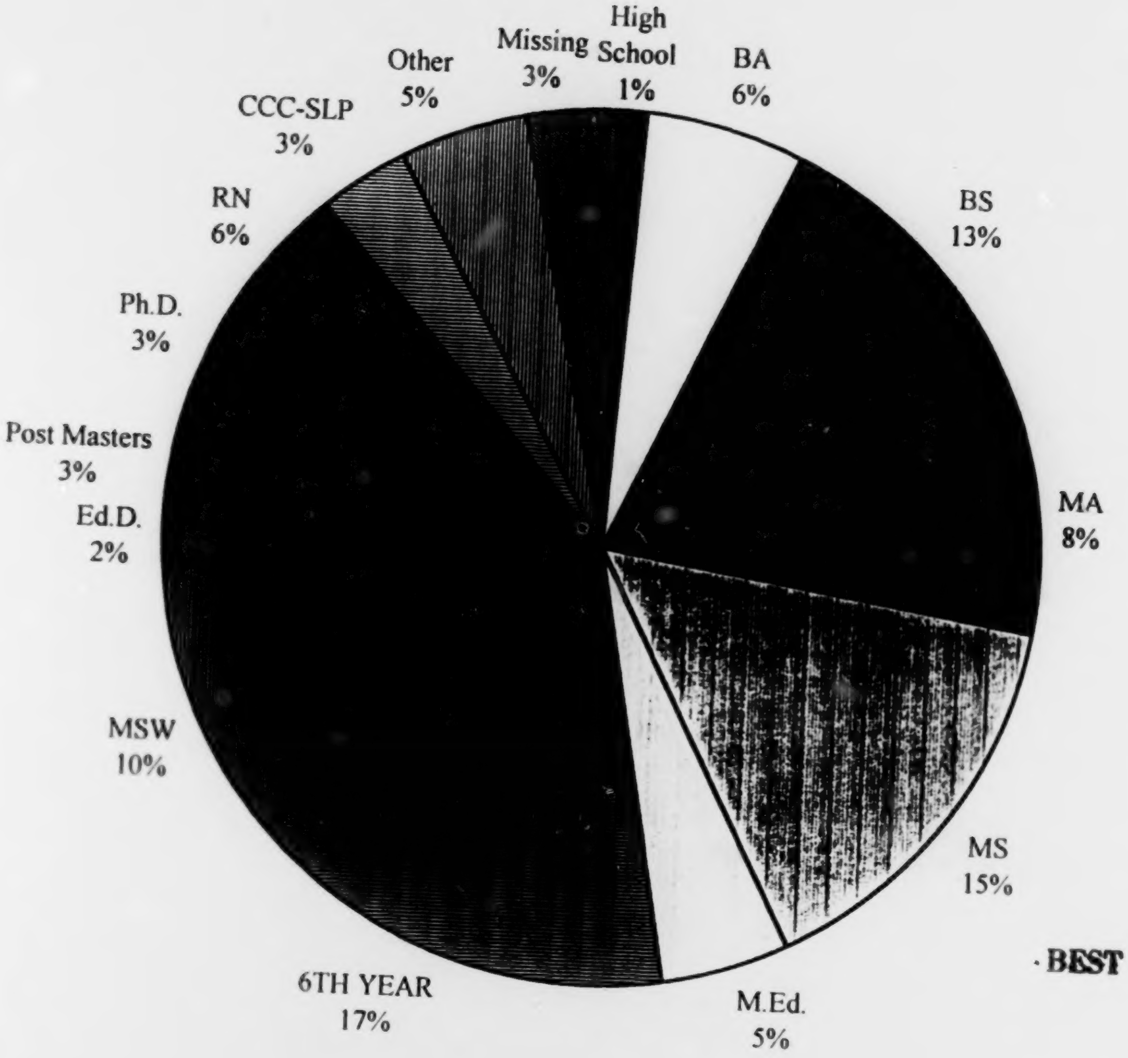
Institute II Participant Information Continued

ID	Role	Age Of Child	Service Region	Job Title	Place Of Employment	Area Of Service Provided	Highest Degree
115	Provider	[redacted]	[redacted]	Speech Path	CES	Speech & Language	CCC-SLP
116	Provider	[redacted]	[redacted]	Director Of Finance	Easter Seal Central CT	Early Childhood Education Administration	
117	Provider	[redacted]	[redacted]	Chief Of Children Services	BESB	Early Childhood Special Education Administration	MEd
118	Provider	[redacted]	[redacted]		Middlesex Hospital		
119	Provider	[redacted]	[redacted]			Social Work	MSW
120	Provider	[redacted]	[redacted]	Teacher	Hill Health Center/Early Stimulation Prg	Early Childhood Education Teacher	BS
121	Provider	[redacted]	[redacted]	RN, Evaluator	Southeast Regional Family Service Coordination Center	Nursing	RN
122	Provider	[redacted]	[redacted]	MCH Supervisor	Meriden VNA	Nursing	RN
123	Both	60	6	Parent Consultant	CT Parent Advocacy Center		BA
124	Provider	[redacted]	[redacted]	Developmental Therapist	The Consultation Center	Early Childhood Special Education Teacher	MS
125	Provider	[redacted]	[redacted]	Social Worker	Easter Seals Rehab Center	Social Work	MSW
126	Provider	[redacted]	[redacted]				
127	Provider	[redacted]	[redacted]	Parent Facilitator	The Consultation Center	Advocacy	
128	Provider	[redacted]	[redacted]	Evaluator	Regional Family Service Coordination Center-Early Connections	Early Childhood Education Teacher	MS
129	Parent			[redacted]	[redacted]	[redacted]	[redacted]
130	Provider	[redacted]	[redacted]				
131	Provider	[redacted]	[redacted]				
132	Provider	[redacted]	[redacted]	Social Worker	Family Advocacy Program Middlesex Hospital	Social Work	BA
133	Parent	42	1	[redacted]	[redacted]	[redacted]	[redacted]

Institute II Participant Information Continued

ID	Role	Age Of Child	Service Region	Job Title	Place Of Employment	Area Of Service Provided	Highest Degree
134	Provider			Teacher	Early Connections Eastern Region	Early Childhood Special Education Teacher	MA
135	Provider			Service Coordinator	Southwest Regional Family Service Coordination Center	Service Coordination	
136	Provider			Speech Pathologist	Greenwich Public Schools	Speech & Language	6TH YEAR
137	Provider				Catholic Family Services		



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Interagency Institute: LICCs Can Lead the Way Highest Degree Earned by Provider Participants (N=87)

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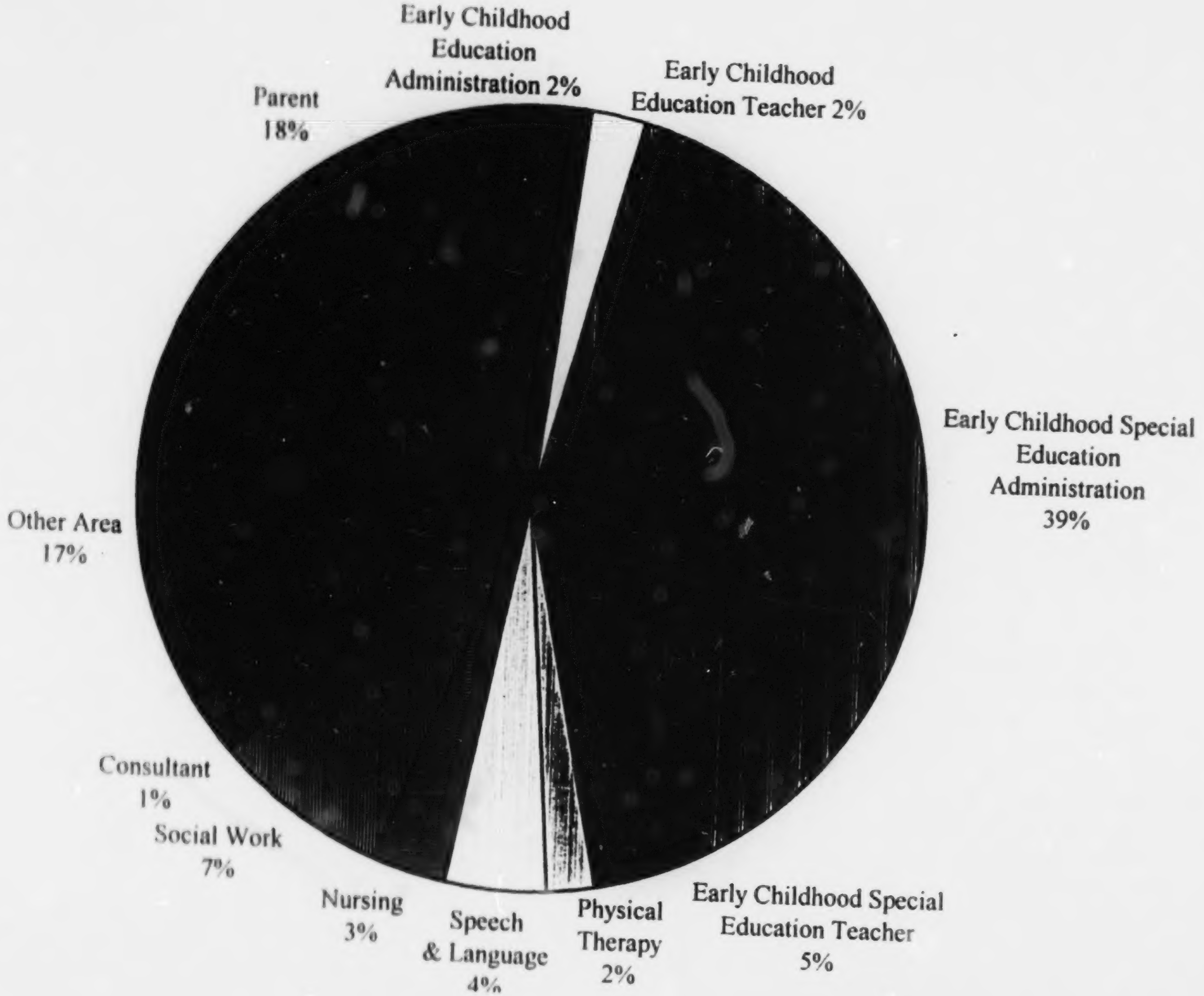

Interagency Institute: LICCs Can Lead the Way Position Held by Participants (N=98)

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Participant Information · Institute III

ID Number	Position/Title	Place of Employment	Area of Service You Provide	Highest Degree Earned	Formal Training Y/N	Years working with children	
						B to 3	3 to 5
001	Director	SWRFSCC	Birth-3 Administration	MS CCC-SLP	Y	0	0
002	Early Intervention Teacher	DMR Teacher	Early Childhood Special Education	MS	Y	14	0
003	Physical Therapist	DMR Early Connections	Physical Therapy	BS	Y	16	13
004	Early Intervention Teacher	DMR-Milford	Early Childhood Special Education	MS	Y	11	0
005	Teacher	DMR-Branford	Early Childhood Special Education	MS	Y	12	7
006	Teacher	DMR-Trumbull	Early Childhood Special Education	MS	Y	12	5
007	Service Coordinator	RFSCC	Social Work	MSW	Y	3	6
008	Early Interventionist	DMR-Bridgeport	Early Childhood Special Education	MS	Y	6	13
009	Speech and Language Pathologist	DMR-Stratford	Speech & Language	MA CCC-SLP	Y	2	2
010	Supervisor	DMR-Trumbull	Early Childhood Special Education Administrator	6th Year Certificate	Y	9	0

Participant Information

ID Number	Position/Title	Place of Employment	Area of Service You Provide	Highest Degree Earned	Formal Training Y/N	Years working with children	
						B to 3	3 to 5
011	Early Interventionist	DMR-Bridgeport	Early Childhood Special Education	MS	Y	4	0
012	Coordinator	DMR-Bridgeport	Early Childhood Special Education	BS	Y	2	2
013	Director of Pediatrics	Rehabilitation Center of Fairfield County	Early Childhood Special Education	6th Year Certificate	Y	35	35
014	Director	DMR-New Canaan	Early Childhood Special Education	6th Year Certificate	Y	14	14
015	Educator	SWRFSCC	Physical Therapy	MS	Y	22	22
016	Service Coordinator	RFSCC	Service Coordinator	MA	Y	2.5	2.5
017	Early Interventionist	DMR-Bridgeport	Early Childhood Special Education/Social Work	MSW	Y	6	6
018	Service Coordinator	SWRFSCC	Service Coordinator	HS	Y	3	3
019	Service Coordinator	RFSCC	Service Coordinator	BA		1.5	1.5
020	Speech/Language Pathologist	DMR-Trumbull	Early Childhood Special Education Speech & Language	MS	Y	2	2 months

Participant Information

ID Number	Position/Title	Place of Employment	Area of Service You Provide	Highest Degree Earned	Formal Training Y/N	Years working with children	
						B to 3	3 to 5
021	Service Coordinator	SWRFSCC	Service Coordinator	H.S.	N	3 months	0
022	Teacher	Easter Seal	Early Childhood Special Education	BS	Y	5	5
023	Speech & Language Pathologist	Easter Seal	Speech & Language	MS CCC-SLP	Y	6	0
024	Speech & Language Pathologist	Easter Seal	Speech & Language	MS CCC-SLP	Y	3	4.5
025	Service Coordinator	RFSCC	Service Coordinator	BSW	Y	6	6
026	Occupational Therapist	SWRFSCC	Occupational Therapy	6th Year Certificate	Y	15	18
027	Physical Therapist	Easter Seal	Physical Therapy	BS	Y	5	5
028	Teacher	St. Vincent's Special Needs School	Early Childhood Special Education	BS	Y	5	5
029	Teacher	St. Vincent's Special Needs School	Early Childhood Special Education	BS	Y	5	0

Participant Information - 5/14 am

Institute IV

Name	Position/Title	Place of Employment	Area of Service You Provide	Highest Degree Earned	Formal Training Y/N	Years Working with Children	
						B to 3	3 to 5
A. Ridgway							
D. S. Frederick	Regional Director	ACES-RFSCC	Early Childhood Special Education Administration	MSW	Y	8	15
K. Austin	Evaluator RN	Project LEARN	Nursing	RN	Y	>20	>20
J. Stack	Evaluator	SERFSCC	Evaluator/Assessor	MA	N	3	0
C. Bunkley	Service Coordinator						
M. Hart	Evaluator/Assessor Occupational Therapist	SERFSCC	Occupational Therapy	BS	Y	10	10
D. Viets	Early Childhood Special Educator	VSD#3 Region 6	Early Childhood Special Education Teacher	MS	Y	10	0
B. Scott	Evaluator	Rescue-Litchfield 0-3(NW)	Early Childhood Education Early Childhood Special Education Evaluator	M.Ed.	Y	.5	9
J. Courtot							

Participant Information - 5/14 pm

Name	Position/Title	Place of Employment	Area of Service You Provide	Highest Degree Earned	Formal Training Y/N	Years Working with Children	
						B to 3	3 to 5
D. Pietras Nolan	B-3 Special Ed Teacher	Danbury Board of Education	Early Childhood Special Education Administration Teacher Consultant	MS 6th year certificate	Y	8	12
L. Pesce	Service Coordinator	NWRFSCC/Birth to Three	Service Coordination	BA	Y	4	4
A. Giordano	Service Coordinator	Rescue	Social Work Service Coordination	BS	Y	1	0
D. Billings-Myhill	Clinical Coordinator B-3	Datahr Rehab Institute	Physical Therapy	BS	Y	6	6
L. Schuler	Teacher	Early Connections			Y	8	0
C. Lawson	Service Coordinator	Rescue	Service Coordination	BS	Y	2.5	0
N. Essency	Supervisor/SLP	Danbury Hospital/Main St. Rehab Children's Dev & Rehab	Speech and Language	MS C.C.C.-SLP	Y	14	18
J. Courtas							
L. Landis	Speech Pathologist	DMR-I	Speech and Language	M.Ph. C.C.C.-SLP	Y	>15	0
K. Howard	Special Educator	DMR WD#3 Early Connect	Early Childhood Education Teacher Early Childhood Special Education Teacher	MS	Y	7	3
M. Macomber	Teacher	Early Connections	Early Childhood Special Education Teacher	MA	Y	6	0
J. Lonardo	RN	Early Connections	Nursing	BS RN	N	6	0

Participant Information - 5/14 pm

A. DiMauro	Early Intervention Teacher .	DMR	Early Childhood Education Teacher Early Childhood Special Education Teacher	MS	Y	4	0
R.O'Hazo							
C. McAdams	Pediatric RN	Danbury Public School Early Intervention	Early Childhood Education Teacher Nursing	RN	Y	4	0
P. Valluzzo	Educator, B-3 Program	Danbury Public Schools	Early Childhood Education Teacher Early Childhood Special Education Teacher Family Training	BS	Y	8	0
D. Allyn	Teacher	DMR	Early Childhood Special Education Teacher	MS	Y	4	15
R. Dunn	Communications Therapist	State of CT DMR Early Connections	Speech and Language	MA C.C.C.-SLP	N	6	0
K. Schlimmer	E.I. Teacher	DMR - Early Connections	Early Childhood Special Education Teacher	BS	Y	>6	0

COLLABORATION TRAINING

Inshhat W1

Name	Phone	Region	Position
Tina Giddings	298-6188	Northcentral	Evaluator
Beth Thomson	298-6188	Northcentral	Evaluator
Jane Greebel	298-6188	Northcentral	Service Coordinator
Carol Spencer	298-6188	Northcentral	Service Coordinator
Eunice Austin	298-6188	Northcentral	Evaluator
Tess MacKenzie	298-6188	Northcentral	Service Coordinator
Rosa Flores	298-6188	Northcentral	Service Coordinator
Neida Matos	298-6188	Northcentral	Service Coordinator
Cathy Bodzinski	298-6188	NCRFSCC	Transition Coordinator
Karen Rusling-Tienmann	298-6188	NCRFSCC	PT/Evaluator
Maureen Dagon	298-6188	NCRFSCC	Service Coordinator
Nancy Canata	298-6188	NCRFSCC	MSW/Evaluator
Carol Lawson	567-0863	Northwest	Service Coordinator
Beth Scott	567-0863	Northwest	Evaluator
Rachel O'Hazo	567-0863	NWRFSCC	Service Coordinator
Laurene Pesce	567-0863	NWRFSCC	Transition Coordinator
Anne Giordano	567-0863	NWRFCC	Service Coordinator
Juleen Flanigan	567-0863	NWRFSCC	Director
Amanda Castro	791-1904	NWRFSCC	Service Coordinator
Diane Steinerd	791-1904	NWRFSCC	Service Coordinator
Noween Hassam	567-0863	NWRFSCC	Evaluator
Janette Echevanier	298-6188	Northcentral	Service Coordinator
Carmen Cotto	298-6188	Northcentral	Service Coordinator
Nancy Creez	298-6188	Northcentral	Service Coordinator
Anna Cormier	298-6188	Northcentral	Service Coordinator
Joanne Pamoss	298-6188	Northcentral	Service Coordinator
Allison D'Allessandro	298-6188	Northcentral	Service Coordinator
Ellen Mary Vincenzo	298-6188	Northcentral	Service Coordinator

Institute VII

Participant Information Collaborations

ID Number	Position/Title	Place of Employment	Area of Service You Provide	Highest Degree Earned	Formal Training Y/N	Years working with children	
						B to 3	3 to 5
001	Speech Pathologist and Evaluator	Southwest Birth to Three Regional Family Service Coordination Center	Speech and Language Therapy	MS C.C.C.-SLP	Y	10	10
002	Evaluator	Southwest Birth to Three Regional Family Service Coordination Center	Social Work	Post Masters	Y	4	0
003	Service Coordinator	Southwest Birth to Three Regional Family Service Coordination Center	ECSE	MS	Y	2	0
004	Regional Director	Southwest Birth to Three Regional Family Service Coordination Center	ECSE Administration, Speech and Language	MS	Y	10	0
005	Service Coordinator	Southwest Birth to Three Regional Family Service Coordination Center	ECSE	HS	N	2	0
006	Service Coordinator	Southwest Birth to Three Regional Family Service Coordination Center	Service Coordination	BA	N	1	0
007	Nurse and Evaluator	Southwest Birth to Three Regional Family Service Coordination Center	Nursing	BS	Y	3	3

Institute VIII

Participant Information Collaborations and Teaming

ID Number	Position/Title	Place of Employment	Area of Service You Provide	Highest Degree Earned	Formal Training Y/N	Years working with children	
						B to 3	3 to 5
001	Speech Pathologist	Hartford Schools and Self-employed	Speech and Language Therapy	MA	Y	10	20
002	Physical Therapist	Visiting Nurses and Community Care, Inc.	Nursing, Therapy and Social Work	BS	N	1	0
003	Teacher	State of Connecticut, Early Connections Program DMR	ECSE Teaching	MS	Y	8	10
004	Transition Coordinator	North Central Regional Family Service Coordination Center	ECSE Administrator	M.Ed.	Y	5	0
005	Rehabilitation Supervisor	Olsten-Kimberly Quality Care	Nursing, Therapy and Social Work	MS	Y	7	7
006	Assistant Director	CREC, Hearing Impaired Program	ECSE Teaching, Administration and Therapy	MA	Y	15	28
007	Physical Therapist	Cross Health Care	Physical Therapy	BS	Y	2	11
008	Physical Therapist	Self-employed	Physical Therapy	BS	Y	14	14
009	Service Coordinator	CREC North Central Regional Family Service Coordination Center	ECE Coordination	BS	N	16	16
010	Director	Newington Children's Hospital, Infant and Toddler Program	ECSE Administration	MS	Y	10	10
011	Office Manager and Billing Supervisor	Greater Bristol VNA	Nursing, Therapy, Social Work and Home Health Aid	BS	N	0	0

ID Number	Position/Title	Place of Employment	Area of Service You Provide	Highest Degree Earned	Formal Training Y/N	Years working with children	
						B to 3	3 to 5
012	Service Director	Key Service Systems	ECSE Teaching and Administration	MA	Y	12	0
013	Co-Director	Project Interact	ECSE Administration and Social Work	MSW	Y	18	18
014	Physical Therapist	Self-employed	Physical Therapy	MS	Y	13	6
015	Director	Care at Home, Maternal and Child Health	Nursing, Therapy, Social Work and Home Health Aid	BS	Y	16	3
016	Educational Coordinator	The Wheeler Clinic	ECSE Administration	M.Ed.	Y	4	16
017	Occupational Therapist	VNA Health Care	Occupational Therapy	BS	Y	8	8
018	Pediatric Therapy Supervisor	Olsten-Kimberly Quality Care	ECE Administration, Speech and Language Therapy	MS C.C.C.-SLP	Y	3	8
019	Teacher	State of Connecticut Department of Education, Early Connections, DMR	ECSE Teaching	6th Year	Y	14	0
020	Teacher	State of Connecticut Department of Education, Early Connections, DMR	ECSE Teaching and Consultation	6th Year	Y	8	2
021	Supervisor	State of Connecticut Department of Education, Early Connections, DMR	ECE Administration	Post Masters'	Y	13	2
022	Physical Therapist	Self-employed	Physical Therapy	MA	Y	12	20

Results of Motivation Questionnaire

Reason	Percentage of Responses		
	Not at All Important	Somewhat Important	Very Important
To develop my collaboration skills	0%	33.3%	66.6%
To enhance my ability to work with other professionals in Early Intervention	0%	16.6%	83.3%
To become better informed about effective negotiation methods	0%	25%	75%
To learn fhow I can assist families in the IFSP process	8.3%	33.3	58.3%
To become more effective in conflict resolution.	0%	16.6%	83.3%
For personal enjoyment and enrichment	33.3%	50%	16.6%
To meet new people	75%	25%	0%
To learn for the sake of learning	33.3%	33:3%	33.3%
Because the location was convenient.	33.3%	41.6%	25%
Because the topic is of concern to me.	0%	33.3%	66.6%
Because my supervisor recommended it.	25%	25%	50%
Because my supervisor required it.	25%	33.3%	41.6%
To help advance in my present job.	16.6%	33.3%	50%

Responses to Problematic Issues Associated with Attendance (N=12)

Issue	Percentage of Responses		
	Not at All Problematic	Somewhat Problematic	Very Problematic
Attending all day.	33.3%	58.3%	8.3%
Attending during work hours.	75%	16.6%	8.3%
Lack of chilld care.	91.6%	8.3%	0%
Transportation difficulties	100%	0%	0%
Friends or family attitudes.	100%	0%	0%
Home responsibilities.	100%	0%	0%
Job responsibilities.	25%	33.3%	41.6%

Results of Consumer Satisfaction - Interagency Institute

	Mean Score for Question by Session (Standard Deviation)							
	1	2	3	4	5	6	7	8
I. CONTENT								
1. Objectives of the training were met.	4.12 (0.64)	4.22 (0.97)	4.59 (0.67)	4.35 (0.49)	3.73 (1.07)	4.18 (0.82)	4.18 (0.68)	4.45 (0.69)
2. All topics on the agenda were addressed.	4.50 (0.62)	4.35 (0.94)	4.36 (0.79)	4.35 (0.61)	3.92 (1.02)	4.31 (0.76)	4.43 (0.75)	4.44 (0.70)
3. The materials (e.g., readings, overheads) were relevant to the training content.	4.68 (0.68)	4.64 (0.95)	4.14 (0.73)	4.82 (0.39)	3.89 (1.03)	4.25 (0.70)	4.53 (0.60)	4.67 (0.55)
4. Adequate illustrations and examples were used during presentations.	4.52 (0.62)	4.43 (1.07)	4.17 (0.72)	4.69 (0.48)	4.08 (0.88)	4.17 (0.64)	4.38 (0.63)	4.50 (0.78)
5. Time was well organized.	4.18 (0.80)	4.26 (0.94)	4.26 (0.81)	4.18 (0.64)	3.29 (1.25)	4.04 (0.82)	4.20 (0.76)	4.43 (0.68)
6. The informa-tion is relevant and can be applied to my work situation.	4.32 (0.77)	4.50 (0.75)	4.36 (0.85)	4.56 (0.73)	4.21 (0.84)	4.44 (0.64)	4.26 (0.76)	4.77 (0.63)
7. I feel I now have a better understanding of the subject presented.	4.21 (0.77)	4.46 (0.88)	4.35 (0.65)	4.29 (0.69)	3.97 (1.08)	4.30 (0.72)	4.31 (0.73)	4.47 (0.90)
II. PRESENTER								
1. The presenters were well prepared and organized.	4.73 (0.63)	4.54 (0.88)	4.52 (0.67)	4.81 (0.40)	4.22 (0.99)	4.48 (0.64)	4.65 (0.53)	4.79 (0.41)
2. The presenters were know-ledgeable in the subject.	4.85 (0.57)	4.68 (0.86)	4.78 (0.60)	4.81 (0.40)	4.28 (0.94)	4.44 (0.66)	4.68 (0.53)	4.97 (0.19)
3. The presenters used a variety of activities that corresponded with the content.	4.24 (0.71)	4.30 (0.82)	4.00 (0.71)	4.38 (0.62)	3.81 (0.95)	3.90 (0.77)	4.05 (0.86)	4.66 (0.55)
4. The presenters were easy to listen to.	4.52 (0.62)	4.43 (1.00)	4.43 (0.66)	4.69 (0.48)	4.31 (0.86)	4.22 (0.63)	4.46 (0.64)	4.86 (0.35)
5. The presenters valued our input.	4.55 (0.71)	4.29 (1.01)	4.36 (0.85)	4.81 (0.40)	3.94 (1.17)	4.29 (0.83)	4.65 (0.66)	4.83 (0.47)

Mean Scores are defined by the following scale:

- **1** indicates that you strongly disagree with the statement,
- **2** indicates that you mildly disagree with the statement,
- **3** indicates neutral,
- **4** indicates that you mildly agree with the statement,
- **5** indicates that you strongly agree with the statement.

	Mean Score for Question by Session (Standard Deviation)							
	1 N=34	**2 N=28**	**3 N=23**	**4 N=17**	**5 N=38**	**6 N=56**	**7 N=40**	**8 N=31**
III. LOGISTICS								
1. I found the environment to be comfortable.	3.76 (0.90)	3.93 (1.12)	4.04 (0.71)	4.19 (0.83)	3.66 (1.14)	4.11 (0.78)	4.22 (0.97)	4.03 (0.91)
2. There was adequate time for breaks during the training sessions.	3.97 (0.77)	4.25 (0.93)	4.26 (0.62)	4.63 (0.62)	3.69 (1.17)	4.20 (0.65)	4.53 (0.60)	4.69 (0.47)
3. The size of the group was appropriate for the sessions.	4.36 (0.74)	4.39 (0.83)	4.57 (0.59)	4.44 (0.73)	4.03 (0.92)	4.20 (0.75)	4.58 (0.64)	4.62 (0.49)
4. The location of the training was convenient for me.	4.18 (0.95)	4.32 (0.86)	4.17 (0.83)	4.25 (1.06)	3.89 (1.09)	4.21 (0.82)	4.20 (1.02)	4.17 (1.07)
5. The day and time of the training was convenient for me.	4.03 (1.13)	4.43 (0.84)	4.39 (0.58)	4.63 (0.50)	3.92 (1.13)	4.36 (0.82)	4.43 (0.87)	4.52 (0.78)

Mean Scores are defined by the following scale:

1 indicates that you strongly disagree with the statement,
2 indicates that you mildly disagree with the statement,
3 indicates neutral,
4 indicates that you mildly agree with the statement,
5 indicates that you strongly agree with the statement.

APPENDIX E

NORTHEASTERN EARLY INTERVENTION FACULTY TRAINING INSTITUTE
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APPENDIX F

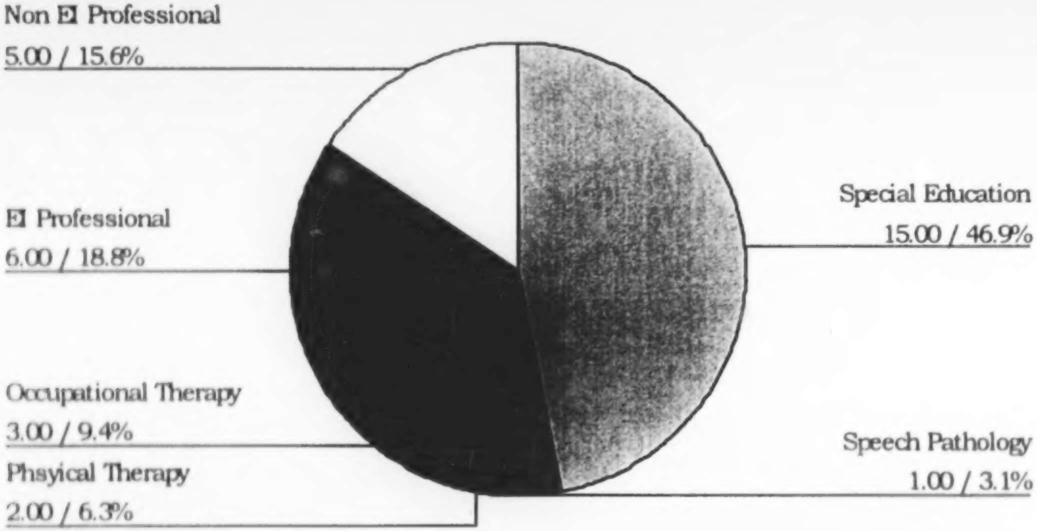

Figure 1 : **Description of Participants in Early Intervention Collaborations Class by Position (n=32)**

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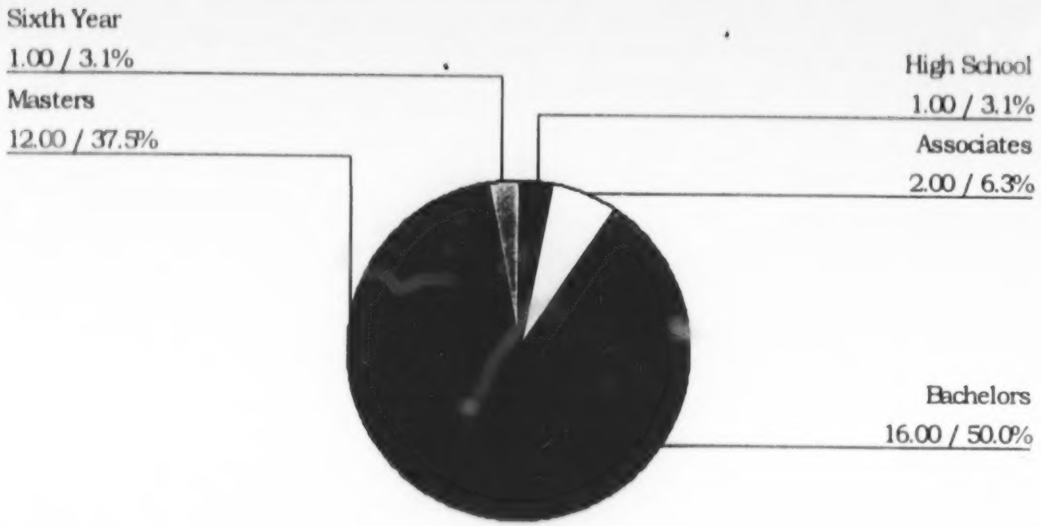

Figure 3 : **Description of Participants in Early Intervention Collaborations Class by Degree (n=32)**

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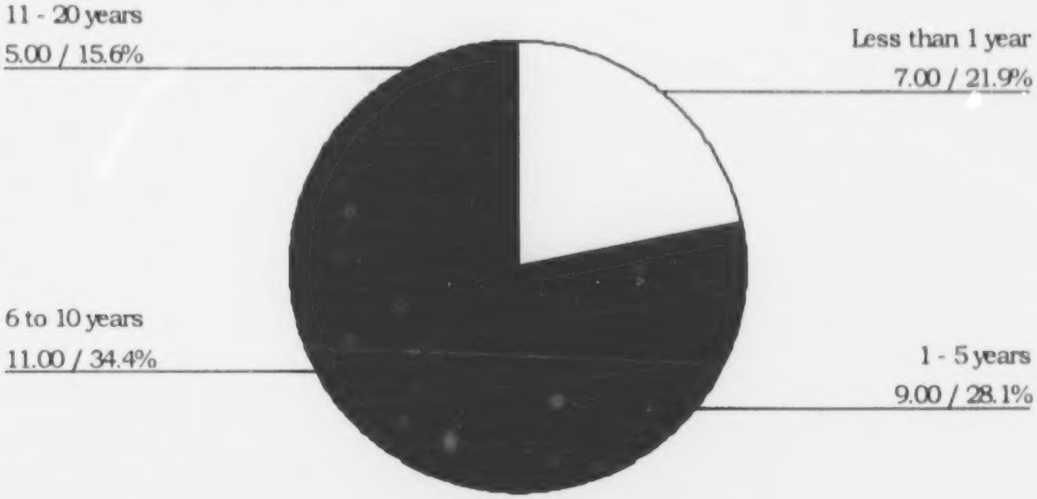

Figure 2 : **Description of Participants in Early Intervention Collaborations Class by Years of Experience**
(n=32)

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APPENDIX G

Purchased Copies of manual, "Collaboration: Putting the Puzzle Pieces Together"

Deborah R. Trelewicz 18 Altiere Drive North Branford, CT 06471	1	12/2/96
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Philipa Campbell, Ph.D. Associate Professor Allegeny University of the Health Sciences Chiild & Family Studies Medical Office Building, Rowland Hall 4190 City Avenue, Suite 403 Philadelphia, PA 19131-1696	1	11/28/97
State of Kansas Department of Administration Topeka, KS	1	12/9/97
Indiana University Center for Innovatie Practices for Young Children Institute for the Study of Developmental Disabilities Indiana University at Bloomington Bloomington, IN	50	12/29/97

Purchased Copies of manual, "Leadership: The Vision beyond the Doorway"

Requester	Number of Copies	Date Sent
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